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The MODERN HOSPITAL

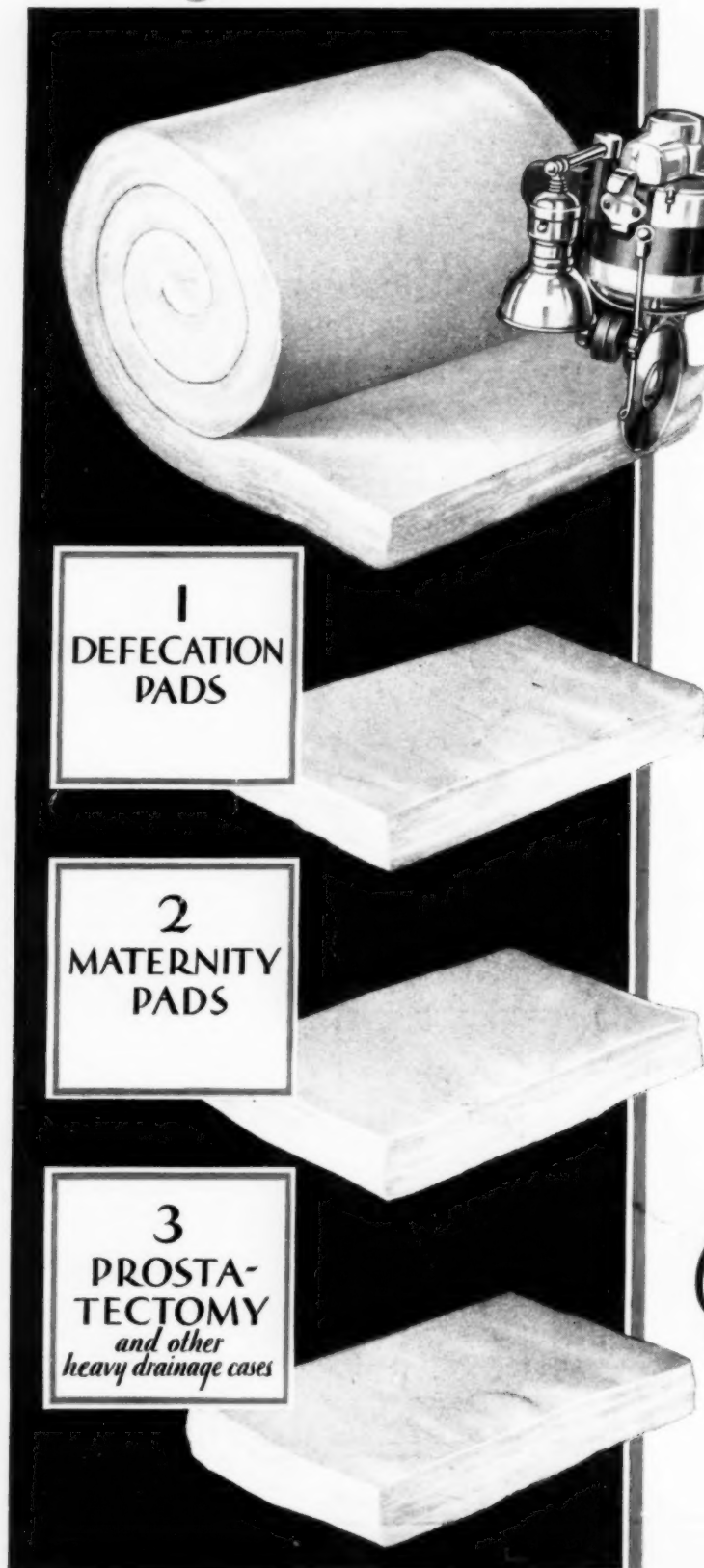
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXXII

June, 1929

No. 6

Training for the Hospital Career

By MICHAEL M. DAVIS, Ph.D.
Chicago

HOSPITALS require more trained executives. This need has been strongly expressed by many hospital managers and other informed persons throughout the country. It has been acknowledged by the national professional organizations who through the work of their standing committees have kept the subject before the hospital world. It has called forth two grants from the Rockefeller Foundation for special study of the question. The second study¹ has just been published and is partly summarized in this article.

What type of training does the prospective hospital executive need? To what extent can hospitals participate? The training required for hospital administration is obviously that of a practical art. The chief educational problem to be solved is more similar to that of training for business than to training in medicine. The hospital includes a variety of highly specialized techniques—medical, financial, personnel and others.

Experience of the university schools of business has indicated that it is neither practical nor desirable to attempt to give a future executive an operating knowledge of all or even many of the techniques of the business studied. Knowledge of the general nature of the chief techniques is essential and a more intimate knowledge of a few, especially personnel management, accounting and statistics. The broad educational problem, however, is to deal with the fundamental tasks of administration, namely, to solve the

problems of interrelation, cooperation and supervision. The administrator must be taught how to recognize problems, to analyze them and to determine what facts are needed to solve them; how to get the facts and how to utilize them.

The training of the hospital administrator, therefore, centers in the actual job in the hospital more than in the classroom. By the apprenticeship method various operating techniques may be learned by rule of thumb, and under favorable conditions more or less of principles may be absorbed. A rightly planned learning process should give no less practical a training than an apprenticeship, and should short-circuit its deficiencies and wastes.

Comparative Study Fruitful

Comparative study of courses offered by schools of business, particularly in Harvard, Chicago and Columbia, has proved fruitful. The main divisions of the business curriculum usually include (1) business policy, (2) business organization, (3) management, (4) marketing, (5) risk and risk bearing, (6) financing, (7) accounting and (8) statistics. Certain features important in the business curriculum are of practically no value to the hospital administrator. The problems with which they deal do not exist or are not significant in a noncompetitive business that has no tangible product to sell, as for example, marketing, risk and financing. Business policy and business organization are of direct value. The material usually presented under "management of production" has value chiefly in relation to personnel management. Accounting and statistics are of fundamental importance, and are taught in the

¹ Davis, Michael M., *Hospital Administration: A Career—The Need of Trained Executives for a Billion Dollar Business, and How They May Be Trained*. New York, 1929. Copies may be obtained by writing the author at 925 South Homan Avenue, Chicago, or through THE MODERN HOSPITAL.

school of business from the point of view of the administrator. The administrator should not be a bookkeeper. He does need to know principles of accounting in order to determine what facts are needed to display the financial status and performance of the hospital, and how these facts are to be obtained and utilized. He should not be a compiler of figures, but he should know how to secure, analyze and present effectively figures that will inform himself, his board and the public of the work done and the results achieved by the hospital.

Thus certain sections of the schools of business curricula cover for the hospital administrator the broad principles of organization and management and some essential techniques of control.

The hospital administrator is concerned daily with two important practical techniques, the engineering problems of the plant and the principles and methods of food service (dietetics). In university schools of engineering and of home economics the teaching of these has been developed, but from a point of view adapted to the engineer or the dietitian, respectively, rather than to the hospital man. In the Cornell University School of Hotel Administration, Ithaca, N. Y., the teaching of this material has been worked out with reference to the needs of the hotel manager, in a fashion directly applicable to a hospital course.

This hotel course furnishes valuable suggestions as to subject matter and educational method. But the man who had had the hotel course would be as much and no more trained to administer a hospital than a man who had had training both as an engineer and as a steward would be fitted to be the commander of an ocean liner. The captain must have at his command the science and art of navigation in addition to any operating techniques.

Foundation Is Necessary

In general, certain conditions must exist before training of hospital administrators can get beyond the paper stage.

1. Practical work in the hospital and the clinic must be the heart of the training educationally, just as are the clinical years in medicine, case instruction in law or case study and supervised observation in a school of business.

2. This practical work must be under continuous, skilled and salaried educational supervision. Otherwise it will not be training, but only hit-or-miss observation.

3. The person furnishing the supervision must be familiar with the administrative problems of hospitals and clinics, must also have qualifications as a teacher and must be expected and paid to

give a major proportion of time to the educational work. Two of the three chief attempts in recent years to develop the university training of hospital administrators have failed because it was expected that the responsible administrator of an institution could undertake the educational duties without special and continuous relief of his brain and time from administrative responsibilities.

4. Connection with an educational institution, such as a university, is essential in order that an educational point of view should infuse the course and also in order to make available at minimum expense many of the classroom courses needed by the hospital student.

5. Important classroom courses needed by the hospital student will be found in the school of business, especially business organization, accounting and statistics.

6. Highly important also are courses or material for courses found in schools or departments of public health and social science.

7. Existing courses in business and other schools may require more or less adaptation to meet the needs of the hospital student satisfactorily. In each university conditions in this respect will differ. Courses must be studied individually to determine their availability as they stand or the degree of adaptation required.

Entrance Requirements Essential

8. Definite entrance requirements are essential, specifying the age and previous preparation of the student in order to secure educationally coherent groups.

9. Throughout the course and more particularly in the practical work in the hospital and the clinic, the project method of teaching is essential—the assignment of the student to study problems rather than merely to report observations.

10. Those concerned with the teaching of the hospital student, and particularly with the supervision of his practical work, must develop syllabuses, textbooks and case material. The subject matter of the hospital field has not yet been put into forms adapted for teaching purposes.

The medical function of the hospital demands, as has been emphasized, a knowledge by the administrator of certain medical subject matter and value. These must be in part acquired by contact and experience rather than by instruction. But for those with a physician's or with a nurse's training and also for laymen and laywomen, there is needed (what neither the medical nor the general college curriculum contains) a course in the history and present status of the medical professions (chiefly medicine and nursing) and of medical institutions (hospitals and clinics). Such

a course should be partly historical and partly descriptive of existing professional groups and organizations. The physician or the nurse entering administrative work needs this course for background, and as a basis for reinterpreting the hospital and the clinic in administrative terms. For the layman, such a course would not be intended as a substitute for medical training, but it would greatly assist him in understanding the hospital, the clinic and their personnel.

The community functions and relationships of the hospital and the clinic again cannot be learned by instruction alone. Two essential groups of subject matter—public health and social science and practice—should, however, be in the mind of the administrator and should be taught as foundation for the essential supervised practical work.

Needs of Specialized Groups

The subject matter of economics, of the social sciences and of law has, of course, been fully developed pedagogically, but not with reference to the needs of many specialized groups. College and university courses as offered in these branches would be of slight direct value to the administrator, though it would be well if a student had taken one or more of them during the undergraduate period. The organization of this subject matter for teaching from the present point of view has been best developed in the schools of social work—particularly in Chicago, Boston and New York. The legal aspect is a specialized technical phase on which qualified lecturers must be sought.

In both graduate and undergraduate courses over 50 per cent of the students' time would be taken up with "supervised practical work" and conferences based thereon. During this time they would be taught the important departmental techniques of the hospital, such as purchasing, admitting, care of stores, supplies, food, laundry and the physical maintenance of the plant. To instruct a student in purchasing in an effective way, for example, he might be furnished with a syllabus giving in outline the main items and divisions in which tasks included under purchasing usually fall. The common elements affecting all types of buying, such as control through purchase orders, requisitions and inventories, would thus be brought out. The many different kinds of purchases from food to medical supplies and instruments would also be emphasized.

Through conferences with a hospital superintendent or an administrative assistant actually concerned with buying, a group of students might learn the method employed in a particular institution under its existing conditions. This could be

followed by observation of the actual procedures and work of the personnel concerned. The information gained by a study of the syllabus plus a preliminary lecture or two would guide the student in his interpretation of what he saw.

Following this period of observation would be a conference with the coordinating instructor, which would help the student to understand the lectures and observation and to generalize from them the principles involved. This would prevent his taking away merely the memory of specific methods which would require modification in detail to fit another institution.

Other administrative problems might be studied in a similar fashion. A certain amount of assigned reading would also be provided for, so that what the student saw and heard could be supplemented by other experiences. The student would not have a roving commission to observe, study or participate in the work of a hospital or a department but would be started out on each assignment from a definite approach and with an announced objective or problem on which to report.

Training the Administrator

This review of educational subject matter and method may be summed up by saying that the task of training the hospital administrator requires that we:

1. Furnish understanding of the essential medical, public health and community functions of the hospital and the clinic through conferences, reading, lectures and observation in hospitals and clinics. In the case of physicians and nurses, it is essential to reinterpret the already familiar subject matter of these institutions from the point of view of the administrator and the community.

2. Give the student a series of problems in the hospital and the clinic which he must study out in person, collecting the necessary facts and preparing a report as to a manner of dealing with the problem, or a report as to the method whereby the institution has actually dealt with it. By this method of instruction the student deals with projects instead of being a passive recipient of information who is given a series of selected problems. This method will teach the essential policy making tasks of the administrator, at the same time bringing him in close contact with certain important operating techniques and with personnel management.

3. Give the student, through observation supplemented by conferences, an understanding of hospital departments and technical methods.

4. Supplement the specialized work in hospital problems by broader training in principles

of business policy and organization, such as are given in courses in schools of business.

5. Teach two essential techniques of management, namely, accounting and statistics from the administrative point of view.

The hospital field can, in the main, be divided into two types from the standpoint of opportunity for the individual and of the scope and character of the education required. These two types may be described in hospital language as the large and the small hospital, respectively; and in educational language as the graduate type on the one hand and the undergraduate type on the other. To the first class belong the executive officers of large hospitals; to the second, the superintendents of twenty-five to fifty-bed hospitals. The types of men and women who can be attracted and who will be held in these differing positions are most concretely illustrated by the salaries of \$10,000 a year and more, with residence, offered at the one end, and \$2,400 a year or less, with maintenance, offered at the other. Statistics regarding salary and tenure of office are presented in the full report.

Two Courses Advisable

Students so widely varying in age, previous education and experience cannot be brought together in the same course without vitiating educational results. Hence one would naturally think of developing two courses, one for the student who had already secured a college degree or a professional education in medicine, business or public health; the other designed for students of less maturity and more limited education.

Before such courses could be satisfactorily carried on, however, it would be necessary to develop educational material and teachers, and to establish and try out methods whereby supervised practical work in the hospital and the clinic would be educationally effective.

A research institute for hospitals is a national need. Such an institute would from the beginning be a training center, though at first perhaps incidentally. Its ultimate function would be largely training. It should be established in a university of standing and should have close affiliations with at least four university departments (or "schools") namely, medicine, public health, business and social science. The hospitals and clinics directly affiliated with the university, and other hospitals having less intimate though no less cordial relations, would furnish its working laboratory. Its work should be on a graduate basis enabling students to secure university recognition as candidates for graduate degrees, or for certificates, according to the courses taken.

The scope of its research would include both community and internal problems of hospitals and clinics, together with the educational problems of determining and developing subject matter and methods of teaching it, adapted to various types of students and to the needs of the hospital field.

The scope of its educational work should be primarily graduate, at least for the opening years.

To meet the demand, particularly of the small hospital, an undergraduate course could be developed inexpensively in almost any university center which contained a business and a medical school with its affiliated hospitals and clinics. Courses of this type are ultimately needed in several parts of the country.

Experienced Leader Important

The most essential requirement for success either in the institute or for an undergraduate course, is a leader experienced in hospital administration and in teaching, and free from the burdens of detailed administrative responsibility.

Hospitals in the United States involve almost a billion dollars' annual expenditure, over four billions of invested capital, the occupation of about 600,000 persons, the care of ten to twelve million sick persons annually, the education of the medical and nursing professions, and intimate relations with the sciences and arts dealing with the study, treatment and prevention of disease.

The annual budget required to enable a university to get under way an adequate educational program to serve these vast interests effectively would be less than one two-hundredth of 1 per cent of the annual hospital expenditure. If capitalized to provide a permanent endowment, the budget would be only about one-fifth of 1 per cent of the capital funds now invested annually in hospitals in the United States.

The Why of Keeping Complete Social Service Records

The main essentials in keeping good records in the social service department of the hospital, according to R. C. Cabot in *Hospital Social Service*, are:

That they should be written or dictated within a short time after the events to which they refer; that they should be summarized at stated intervals, say every three months, the worker then recording briefly what she thinks about the situation and about the prospects, including the patient's strong points as well as his weak points, physical and mental; that records should be read, criticized and discussed by all workers belonging to the staff of the institution in which they are made; that both facts and impressions must be recorded, neither alone being sufficient.

Buying for the Small Hospital—How Can It Be Systematized?*

By RALPH M. HUESTON

Superintendent, Silver Cross Hospital, Joliet, Ill.

IN THIS day of the modern hospital when administrators are confronted with the necessity for making the hospital self-sustaining, they are realizing the great importance of the problem of purchasing and are giving more and more attention to it. Since the problem of purchasing is a subject far too large to cover in one short article, only a brief outline of some of the problems is presented.

The four principal parts of the problem of purchasing are purchase, receipt, distribution and use. Honest competition more than any other one thing probably helps the buyer to get the best price possible. It is a good policy to have more than one main source of supply for every item of purchase. The administrator should know

that he receives what he buys—quality, style, amount. He should see that each item is distributed where it is needed, and then properly used.

More money probably is spent for supplies for the culinary department than for any other department in the hospital. This department more than any other offers an opportunity to save money by an intelligent policy of purchasing. Since many items in this department are purchased by the pound, it is well to have scales available to check the weight of all such merchandise. When letting a contract for the delivery of milk and cream, the administrator should be sure to incorporate in the contract the minimum butter fat content of each item. It is advisable to follow up this contract with tests made regularly in the laboratory to see that the hospital is getting the butter fat content the contract calls for.

*This is the second of a series of articles on small hospital problems. The first, "Credit Policies That Reduce Losses in the Small Hospital," appeared in the April issue of THE MODERN HOSPITAL.



Grocery storeroom in the Cook County Hospital, Chicago.

The terms that represent the four different classes of eggs—strictly fresh, fresh, short held and storage—should be thoroughly understood if the purchaser expects to buy intelligently. The net weight of the eggs is sometimes a factor that warrants a difference in quotation.

The operating cost of an adequate cold storage space will be saved many times over by the advantages it affords for buying fresh meats and fresh vegetables in quantities. Canned vegetables and canned fruit should be purchased largely in No. 10 cans, and the net weight as well as the quality of the contents should be taken into consideration. The number of servings to each can is an important item to consider. Take sliced pineapple as an example. Some No. 10 cans of sliced pineapple have only twenty-nine to thirty slices, others have forty to forty-one slices and still others have fifty to fifty-two slices. There is a very slight difference in the actual sizes of the slices and a very great difference in the cost per service.

Some hospitals have found it more advantageous to serve peaches sliced, claiming that this type of service is more economical, that it can

be made more attractive and that the patients usually prefer to have the peaches sliced. Many such items in the buying of canned goods afford opportunities for saving. The price of individual tea balls is so near the price of bulk tea of a similar grade that the hospital can well afford to serve tea from individual tea balls, both because of the service advantage and from an advertising standpoint. It has been said that one of America's most successful restaurant men attributes his success to the high quality of coffee he serves. Hospitals might well learn a point of advantage in food service from his experience.

The administrator's selection of an engineer, whether he be a chief engineer or a combination engineer and fireman, will materially affect the cost of fuel for heating the hospital. The engineer, if he will exercise the proper interest, can save the hospital a great deal of money in the use of fuel and he can be of great assistance to the administrator in the selection of the fuel. Most hospitals contract for fuel by the season, for delivery in car lots as needed. On all carload shipments the hospital should require the mine's original shipping notice so that a positive check can



An alcove, Mt. Sinai Hospital, New York City, showing shelving for stationery and printed forms.



Grocery storeroom in the Buffalo City Hospital, Buffalo, N. Y.

be made on the quality and tonnage billed to the hospital.

The cost of the linen service of the hospital is sufficiently large to warrant the administrator's giving a great deal of thought to it. Unless there are ample means for getting a definite check on the service, it is well worth while to buy only recognized materials of known quality. Often this policy necessitates paying a slightly higher original price than when substitute materials that are "just as good" are bought, but in the end the unit of service cost will probably be less.

Matters of insurance are usually the business of some committee or some member of the board of directors. The administrator of the hospital, however, is in a position to be of assistance to the board in giving advice that will effect a reduction in the rates or cost of insurance. In one hospital where the building containing the laundry and the boiler room was attached to the hospital building by a one-story connection, a saving of \$400 a year in the fire insurance rate was made by the

installation of a suitable fire door separating these two buildings. A roentgenologist in another hospital was paid out of the pay roll fund although he was not a regular employee. This roentgenologist maintained a private office and did the x-ray work for the hospital on contract for a certain percentage of the receipts of the department. The hospital does not have to cover this type of an employee with compensation insurance, and it can protect itself by demanding a signed release for compensation insurance demands in case of accident.

One administrator, through a rescheduling of the hospital employees, saved the hospital several dollars of the cost of compensation insurance. To get the benefit of a reduction in fire insurance rates from the installation of fire protection equipment it is necessary that all such equipment have on it the insurance underwriters' label. It is possible, however, for equipment to have the underwriters' label without its being the proper equipment. As an example, a single partition

door might be put in a location demanding two fire wall doors. One is only fire resisting up to a given capacity; the other is an accepted cut-off. Almost all hospitals have metal files in which to store x-ray films. If the hospital expects to get credit for these files they must also carry the underwriters' label. Before buying any fire protection equipment or before making any changes in the building or equipment that will affect the insurance rates, the administrator should consult the local insurance inspection bureau.

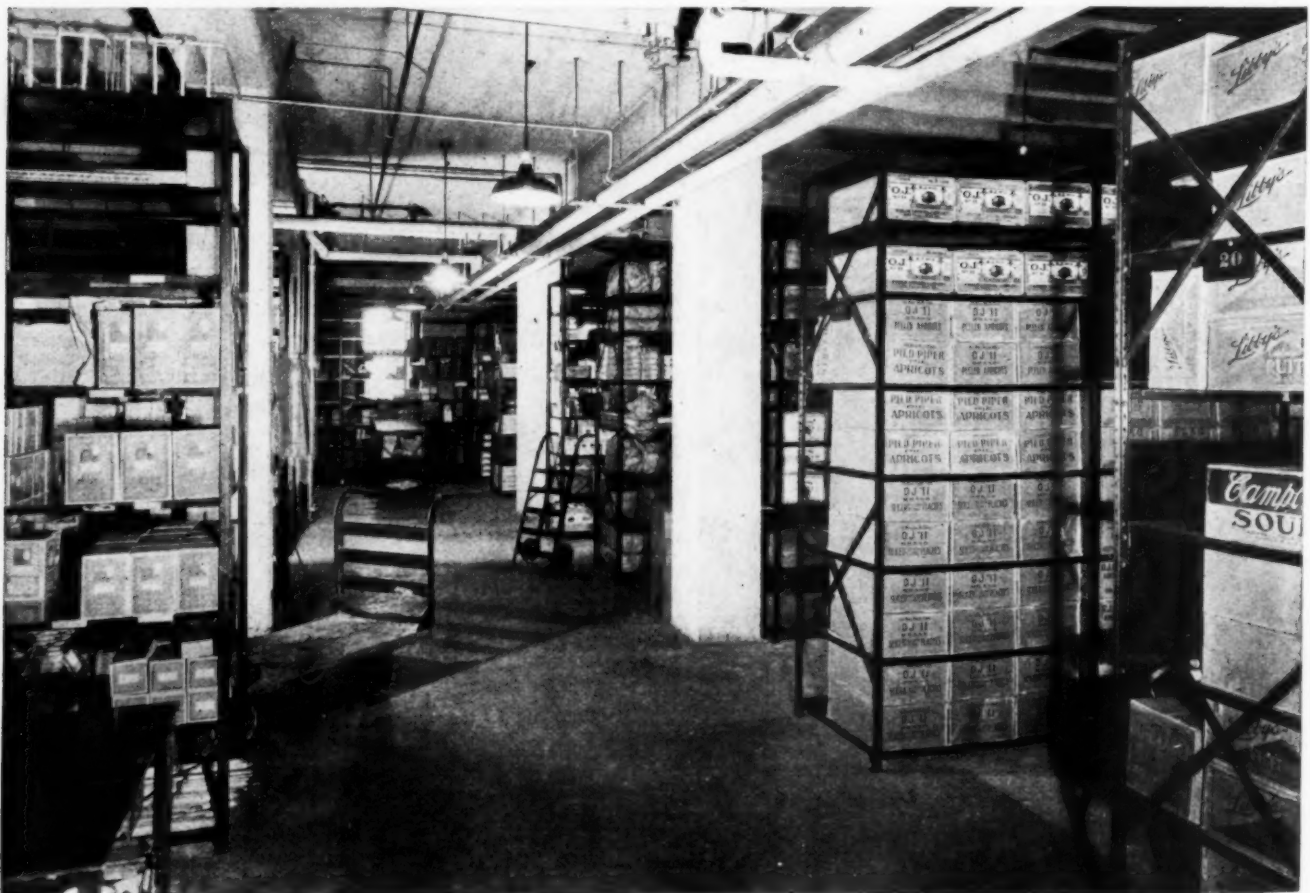
Sometimes it is necessary for the salesman to require the buyer to sign an agreement or contract of purchase. The buyer should be careful to understand clearly the terms of the agreement. It is possible for the salesman in his endeavor to make a sale to become over enthusiastic and to promise more than the agreement calls for, or it is possible for the salesman to fail to explain clearly all the details pertaining to the purchase.

One hospital reports a good example of a misunderstanding. The necessary apparatus, cystoscopic table and x-ray equipment, was purchased for a cystoscopic department. The salesman stated that the price included the cost of the equipment installed. The buyer, not being experienced in the purchase of such equipment, accepted the

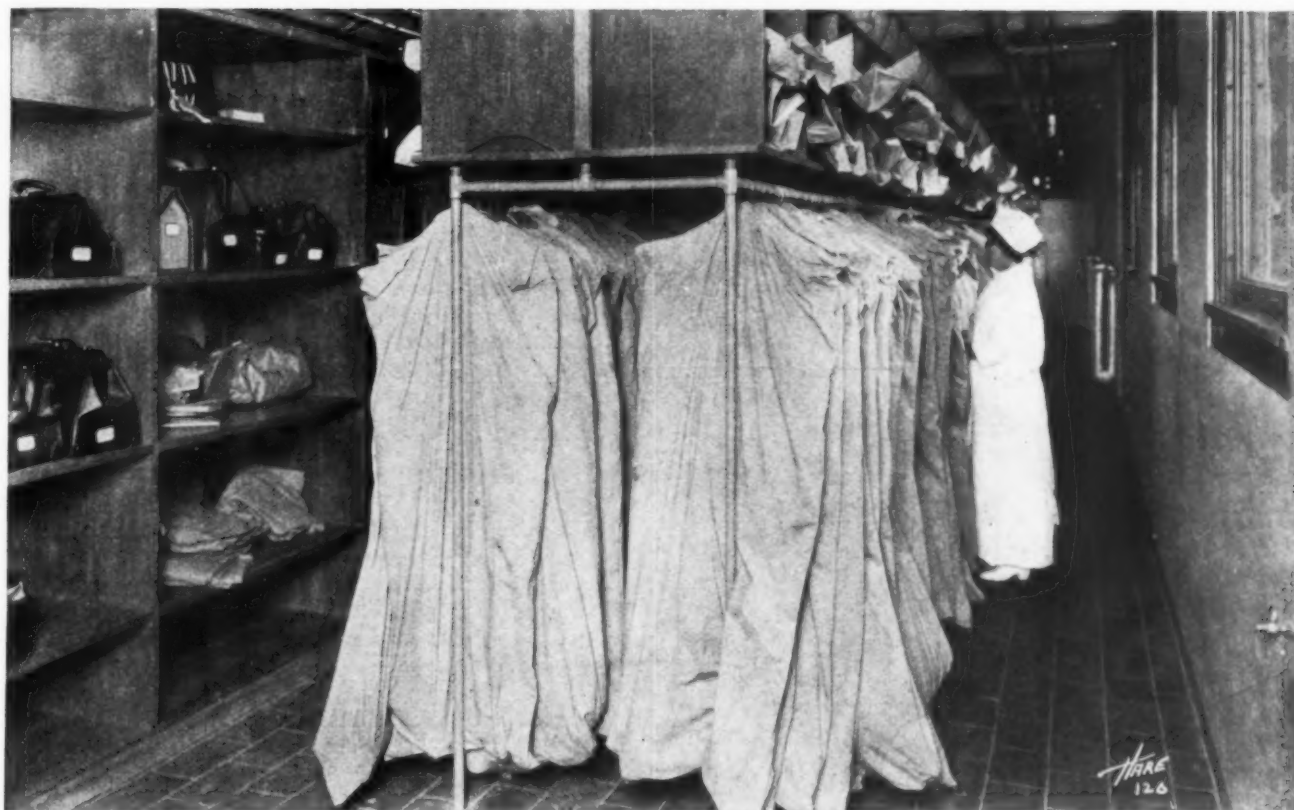
salesman's statement at its face value and signed the contract of purchase without paying much attention to other than the cost terms. The entire appropriation was spent for equipment. The following additional expenses were encumbered: first, the cost of freight and drayage on equipment, \$26.40; second, the cost of bringing the necessary wires from the transformer pole to the department, and the cost of the aerial and the inside electric work, \$219; third, electrician's time to complete the necessary electrical work in the department, \$32; fourth, workman's time to install the necessary brackets on walls and ceiling, \$4.

The salesman, who was also the installing engineer, uncrated the cases, assembled the equipment and tested the equipment so that it was turned over to the hospital, installed and ready for use. He failed, however, to advise the buyer of the preliminary electrical work necessary before the cystoscopic equipment could be installed.

Changes in personnel have a decided effect on the cost of supplies, and this effect is probably most noticeable in the housekeeping department. To know the unit value of supplies for the multiplicity of services in this department is not the privilege of the average housekeeper. Too often



Storing space for groceries is spacious in the Vanderbilt Hospital, Nashville, Tenn.



Patients' clothing is well protected at the Buffalo City Hospital, Buffalo, N. Y.

it is necessary to go through a period of experimentation before a policy of purchasing is decided on. It is not my purpose to recommend the kind of supplies to be used. I should like, however, to call the buyer's attention to the fact that the basis of cost is the unit of service and to recommend that the buyer consider this when making purchases.

Buying in quantities has advantages but the buyer should also consider the disadvantages. The chief advantage of such a policy is a lower unit cost. To offset this advantage there are three possible disadvantages: First, employees usually will not exercise great care in using supplies when there are large quantities in store; second, depreciation, and third, unaccounted for shrinkage. The buyer should consider carefully the disadvantages as well as the advantages when buying in quantities.

Through the efforts of both national and local hospital organizations a splendid spirit of cooperation has been developed among administrators. This has been of great assistance in helping the administrator to solve many of his problems. Through the medium of a questionnaire or a letter one administrator may secure from other administrators collective information of their personal experiences. The administrators will profit greatly by seeking the advice that hospital organizations and other administrators are willing and

glad to give. Especially is this assistance of value when the making of permanent improvements or the adding of highly scientific equipment is under consideration.

The purchase of merchandise is the most important but not the only phase of the problem of buying. It is a good policy to receive the merchandise into the stores and supplies department of the hospital before the merchandise is distributed for use, although at times it may seem unnecessary. Too often merchandise has been distributed without a proper record being made of its receipt. This policy has resulted in many losses to the hospital which naturally has a definite bearing on the cost of supplies for the hospital.

A record should be kept of all outgoing merchandise as well as of all incoming merchandise. There are some items of merchandise purchased by the hospital on which a credit is allowed for the return of the container. Unless a detailed record is kept there is no positive way to check these returned items and there is a possibility, because of incomplete records, of losing the advantage of the credit for containers which might be returned.

Buyers have found it to their advantage to maintain some system for keeping account of purchases. A file for this purpose is often a valuable reference in making repeat purchases or in

estimating the amount of any one item used over a given period.

Adequate space should be provided for the storing of supplies. In the smaller hospital especially, it is advisable to have only one general storeroom. Consideration should be given to the location of the storeroom so that it will afford the best advantage both for the receipt and for the distribution of supplies. The size of the storeroom should be sufficiently large to permit the proper storing of supplies. The storeroom should be arranged with shelves, bins, drawers, boxes and open floor storage space so that a detailed system of keeping a storeroom may be maintained.

The supplies having been purchased and received into the stores and supplies department, the next step in the problem of buying is the distribution of the supplies. The administrator's system of inventory is the basis of his system for the distribution of supplies. How much detail is necessary will be determined by the accuracy of the system of cost accounting. There are many places in the hospital where a saving of supplies can be made through the cooperation of one department with another. An excellent way to know whether or not a saving of supplies is being made is to have records of the distribution of supplies for comparison.

Double Inventory System

One good method of checking the proper distribution of supplies is to keep a double perpetual inventory system for supplies—one for supplies in stores and one for supplies in use. A requisition system should be used in connection with the inventory system. The requisition blank could be arranged for more than one item except where a perpetual inventory system is kept and then it should be arranged for only one item. The single item requisition blank for perpetual inventory systems is recommended because of its convenience to the bookkeeping department.

Since the unit of service is the basis of the cost, it must necessarily be the basis of purchase. The original price is a secondary factor in the cost of supplies. The cheapest hospital supplies are often the most expensive in terms of service and the most expensive are often the cheapest.

With each day bringing greater demands on the administrators of hospitals for more business-like methods of operation, with the great amount of money that is being spent for supplies and with the possibilities for saving on the cost of these supplies through a suitable system of purchase, receipt, distribution and use, administrators can well afford to give more and more attention to the problem of buying.

Are Hospitals Exploiting Their Radiologists?

Are hospitals exploiting their radiologists?

In a great many instances they are, an article in the *Journal of the American Medical Association* says, and not until the relations between hospitals and radiologists have improved will there be a satisfactory development of radiology in hospitals.

The article continues: "The amassing of profits by the hospital from the radiologist's services constitutes exploitation whenever such profits exceed what can be justified by the material outlay and investment in apparatus and space.

"The institution with a qualified radiologic consultant does four or five times as much work as the hospital in which only the technical side of radiology has been developed, or in which the radiologist is available for consultation for only a small part of the time.

"Hospital managements are inclined to put financial return ahead of professional success, and drive away the best radiologists by insisting on retaining the actual control of the department. The hospital is entitled to a fair return on its investment in space and equipment, with a liberal allowance for obsolescence, which is notoriously a big item in x-ray apparatus. Beyond that, in special cases, there may be grounds for a percentage of the net proceeds going to the hospital. But when it is appreciated that every fee collected is in large part a fee for the radiologist's services as a consultant, it is at once apparent that the business arrangements that now obtain between many hospitals and their radiologists amount to nothing more or less than exploitation of those radiologists.

"Why can hospitals hire radiologists at salaries that enable the hospitals to gather in profits they do not earn? Because neither the patient nor the clinician is particular as to who does his radiology. Many physicians and nearly all patients hold that radiology is not a kind of consulting medical practice but a group of technical procedures to be carried out by anyone with the necessary apparatus and technique.

"The system of charges for service by radiologists is fundamentally wrong. It bears too much resemblance to the schedule of charges of a photographic student and scarcely any resemblance to the schedule of charges of any of the other medical or surgical consultants of the hospital."

How the States Rank in Hospitalization

Of all the states Wisconsin makes the best showing for hospitalization with a ratio of 154 persons to a hospital bed, according to the *Journal of the American Medical Association*. Colorado is next with 168; Nevada, 171; California, 173; New York, 184; District of Columbia, 192, and New Jersey, 194.

Among the states having the most persons to a bed for community use are South Carolina with one bed to 749 persons; Oklahoma, 731; Georgia, 666; Arkansas, 658; Mississippi, 644; Alabama, 593, and Kentucky, 502. These states, however, have shown marked improvement in the last eight years and hospital facilities in them are increasing as fast as the demand justifies.

The average for the country as a whole in 1928 was one bed for every 270 persons.

How to Get and How to Keep a Satisfactory Working Force

By ADA BELLE McCLEERY

Superintendent, Evanston Hospital, Evanston, Ill.

AMERICAN industry is learning that good will is the foundation on which business rests and that the good will of the employee is of major importance. Hospitals, then, should no longer expect their workers to feel repaid for having the privilege of contributing to the care of the sick but should face the personnel problem as it is being faced in industry, for no business is more dependent upon good will than a business devoted to the care of suffering humanity.

As far as workers are concerned, industry must be recognized as the competitor of the hospital and a parallel offer must be made, or the hospital must be content to employ culls, the latter promising neither good service nor economy. Is not the contented employee and competent worker as valuable to the hospital as he is to industry? Upon whom does the responsibility for securing and directing the employee group rest?

In studying the question of personnel, it might be suggested that each administrator bear in mind the needs of the institution of which he is the head, for as the hand differs from the foot, so the problem of one hospital differs from that of another, but as the hand and the foot are affected by similar forces and like conditions, all labor problems have much in common.

Many studies have been made of the ratio of employees to patients, but no conclusion has been reached for determining the correct ratio. Such factors must be considered as standard of serv-

ice, length of working day, amount of emergency work, type and size of hospital, convenience of architectural plan, fluctuation of bed occupancy. It must be taken into consideration whether or not bakery, laundry, and repair workshops are maintained; whether or not the hospital is committed to a program of education or research.

However, this lack of an established ratio should not excuse anyone for negligence in scrutinizing duties or making time studies, as such procedures assist in keeping the working force at its proper level by dispensing with unnecessary workers, as well as with the extra ones who were necessary during the peak of a maximum load. Extravagance of personnel is never justified.

The percentage of turnover is an index of the satisfaction of the workers, but vacancies that are the result of promotion and those created by normal social conditions, such as

marriage of girls, should be taken into consideration when interpreting the percentage.

The cost of labor turnover is much higher than the average department head realizes. Industry has made many studies and various estimates, but it is considered conservative by some to conclude that the cost of losing and replacing a man ranges from five dollars for an unskilled laborer to one thousand dollars for a skilled workman. These costs are not always apparent but whenever a change of any kind takes place, a certain disorganization in the department also occurs. The production of the new worker is usually low-

An Administrative Responsibility

THE responsibility for securing and keeping efficient workers rests on the administrative officer, supported by the governing board. In order to maintain such a force, it must be appreciated that the worker is as valuable to a hospital as he is to industry; that given the opportunity, the average man likes to do good work; that he will do better work if he is happy in his working relations, and that his good will is of major importance.

Since this problem is affected by local conditions, it must be solved one step at a time, highly efficient personnel being the result of years of effort and a careful study of requirements.

ered until he becomes accustomed to his environment; he is inclined to waste more supplies; he demands new tools, the saw having lost its cutting edge, the handles being too short on pick or shovel, the mop or broom being too heavy or too light; he must be trained for the particular duties of the new job, while at the same time the experience of the man who had been taught is lost.

In this day of labor saving devices and of technical equipment, the average worker is in contact with fixtures, equipment and machinery, the monetary value of which may be equivalent to his earnings for most, if not all, of his working life. He should be taught values. During this period of learning, should not the expense incurred by an overtaxed elevator, by a misunderstanding of the capacity of a drain pipe, by the ignorance of the effect of muriatic acid on metal or enamel be charged to turnover instead of to that large blanket labeled maintenance and repairs?

When studying the reasons for an abnormal percentage of turnover, one might begin with the department in which the turnover is the highest, contrast it with the department in which it is the lowest and determine as far as possible the underlying cause of each change in personnel. After the cause is decided upon, it must be analyzed in order that the better influences may be strengthened and the others corrected or eliminated. A conscientious effort such as this should result in securing the nucleus of a group of interested contented workers.

Care Needed in Selection

He who flatters himself that he can tell at a glance the individual who will fit the job, seldom remembers the many failures made in selection. Workers might be divided into two groups—those who wish to assume responsibility for the work of others and those who wish personal responsibility only. Unless the worker has what he wishes in this respect he becomes, sooner or later, a misfit. When a high grade worker is assigned to a mediocre job, the job making no demand on his abilities, he soon tires of its monotony. Although workers vary in ability and in ambition, every human being has certain more or less fundamental cravings in relation to his job. These include a consciousness that the job itself is secure, that the wage is adequate, that ability is recognized by advancement and that a reasonable amount of leisure is at his disposal.

Before selecting a worker, the demands of the specific job should be analyzed and a standard set or a scale established whereby the applicant may be judged regarding his fitness. Take as an illus-

tration, the window washer. The name implies the duties and clearly defines the job. What are the prerequisites of the worker? Is physical fitness essential and why? Is agility desirable? Is skill important? Does experience count? What weight should be given to neatness of person, neatness in work? To personality? Should he speak English? What care is expected of tools and equipment?

Criterion for Day's Work

One should set a criterion for a day's work also and decide upon the number of window washers required to maintain the standard of cleanliness demanded by the institution. In establishing the criterion for the day's work, consideration should be given to the type of window, single pane or many panes; location, on ground floor, needing no appliance, on first floor requiring a ladder, on upper floors, a harness. Are bars or screens to be removed and replaced at each window? Do the tools provided hasten or check the speed of the worker? The standard of cleanliness being the same, the windows in an industrial region would require more frequent washings than those in a residential district. Whatever the standard, whatever the job, the supervisor should have a working knowledge of the demands of the job itself and a fairly accurate estimate of an honest day's work.

Since the foundation of the worker's life is his wage, it should be proportionate to his job, and should correspond to the wages paid for similar work in the locality. The increase of the wage should depend upon the increase of the value of the worker. It is conceded, usually, that his value increases with time, but to increase wages on the basis of length of service smacks of increasing them because the service has not been unsatisfactory. An increase is justified if greater skill has been attained; if the quantity of supplies used has been decreased; if improvement has been shown in neatness of person; if there is less necessity for close supervision of the employee's work; if the health record is above the average of the group; if practical suggestions have been made that are worthy of adoption, resulting in greater economy of operation, and improvement in the care of property and equipment; if the employee is possessed of that intangible asset—the ability to get along with fellow workers and to contribute to the general morale of the group.

Although an increase in wage may be justified, there are times when increases cannot be granted because of the lack of funds or because the budget for each department is fixed. In the latter instance, a study may reveal that a combination or

redistribution of duties may make it possible to eliminate one worker in four, increasing the wage of the three workers remaining and leaving a slight margin on the credit side of the budget of the department. This is frequently possible when one member of the group has been promoted, as the rearrangement of duties and increase of wages give the entire group a sense of promotion.

The wage should be paid at regular intervals, weekly, monthly or semimonthly. A definite policy should be established in connection with pay days that fall upon a Sunday or upon a holiday. Payment by check is not a Herculean task if the checks are prepared in sheets of three or more.

Advantages Count as Part of Wage

If it is the custom to give vacations and care during illness, these advantages should be counted as a part of the wage. While many hospitals are almost niggardly regarding vacations, some give one week, others two weeks, following a full year's service. At least one hospital gives fourteen days' vacation at the end of twelve months and an additional seven days at the end of each five-year period. The employee who leaves after a year's service is paid vacation money on the basis of one day for each month since the last vacation. This policy contributes to a sense of justice or fair dealing between employer and employed.

There should be a consistent policy regarding illness. The new worker should not expect to be paid during illness. The established worker deserves consideration, but no one should be paid without a doctor's certificate being presented.

Whether or not the hospital worker should be given gratuitous hospital care is a disputed question. He has no more right to demand free hospitalization than has the worker in industry, but such care is given in many hospitals without question. However, continuation of the wage and gratuitous care should be related to the health record of the individual. Thus a physical examination at the time of employment is a benefit to both employer and employee as the expense of hospitalization is thereby reduced. It is well to remember, also, that it is impossible to give proper care to the sick without having a healthy working force.

Group insurance is beginning to invade the hospital field, its value having been acknowledged in industry for years. Under such a plan the employee, after six months' continuous service, is permitted to take out a policy at group rates without a medical examination, a part of the premium being paid by the insured, the other part by the

hospital. Under this arrangement the premiums are so low that no one can afford to forego the opportunity presented.

No individual does his best work at all times, therefore a study of the percentage of efficiency a worker should be expected to maintain and of the factors that control the variation brings to light the fact that the worker is influenced by both physical and mental conditions.

Under physical conditions might be included such items as cold and damp floors, as in a basement; poor light, caused by neighboring walls or insufficient artificial light; hazardous occupations, as working around improperly guarded machinery, and improper routing of work, such as is often found in kitchens and laundries.

The mental conditions are more difficult to combat because they are more subtle. We should tread softly when invading the privacy of another's thoughts. After confidence has been established, it may be found that the worker is worried over debt, over his inability to save for a rainy day, over a sick wife or child, or there may be domestic friction or even friction with the supervisor of the department. Everyone is not fitted for the same type of work and the job itself may not be interesting enough to hold the worker. Under such circumstances he should be transferred to the type of work for which he is fitted. Whatever reason is discovered for the mental disturbance, the confidence of the worker should not be betrayed and an earnest effort should be made to help him make the necessary adjustments. The worker, in turn, often responds to this evidence of a human interest and becomes a loyal and trusted employee.

Other Conditions Considered

Other conditions or influences classified as minor ones play a part in production. For instance, if tools are provided, the worker should be held accountable for them and for their care, but it should be determined whether or not the particular care the tools require is understood. Proper tools kept in good condition assist in the development of pride in good workmanship.

Pride in the quality of production is stimulated also by the consciousness of being suitably and becomingly dressed for the task. This consciousness is the more easily acquired if a uniform for each group is selected, care being taken that it is comfortable and adapted to the activity in which the worker is engaged. A uniform serves not only as a badge of identification but also as a mark of distinction. When worn by the army, by nurses or by Sisters of Mercy, it is worn proudly, as it is symbolic of devotion to a cause. What-

ever the work, it may be dignified by the worker. Respect for and pride in the identifying uniform foster this spirit.

There is a relationship between the housing conditions in the locality of the hospital and the wisdom of furnishing rooms for employees. Whether quarters are provided or not, one must bear in mind that the type of accommodations available determines in large measure the grade of worker who is attracted to the institution. If responsibility for rooms is assumed, it does not seem that it is taking too much for granted to expect that the same standard of cleanliness is maintained as in the hospital proper, that the furniture is well constructed and easily cleaned, that the bed and chairs are comfortable, that desk space and closet space are available and that the room is a private one, where personal belongings may give it a homelike air and a locked door a sense of security.

Entirely on Cash Basis

The custom of providing food in lieu of wages is probably as old as institutional life. During recent years a new idea has taken root that the worker should have the privilege of handling his earnings, increasing thereby his self-respect since it gives him a cash evidence of his worth. For the accommodation of the worker, cafeterias on a cash basis are being established. In such a cafeteria the sale element enters, with the result that more care is apt to be given both to the preparation and appearance of the food and a greater variety is offered. Under this system the worker becomes the customer who is given a choice of foods and is restricted only by his ability or willingness to pay. Waste of foodstuffs is reduced for the customer buys only that which he expects to eat, and the opportunity to obtain a meal elsewhere on the day off is a recognized privilege.

The number of hours of leisure and the enjoyment of that leisure both hinge on the number of hours in the working day. The aftermath of leisure should be the refreshed worker, hence it is desirable that some provision be made for recreation. If the worker does not live on institutional grounds, the employment of leisure is to a greater extent his personal problem. If he is an institutional resident, provision for his recreation is imperative.

In planning recreational facilities the demands of normal social relationships should be borne in mind. There should be available a comfortable cheerful room, furnished with tables for cards or checkers, a piano, radio or victrola, books and magazines, making it possible to satisfy a diversity of interests without any suggestion of pater-

nalism. If space will permit a room with a pool table for the exclusive use of the men, it results in more normal living than when such facilities are not available.

Such an atmosphere encourages self-improvement. This desire for improvement is shown by the joining of study classes in public schools or through the churches and by the cultivation of musical ability. Incidentally, it satisfies one of the fundamental cravings of the worker.

Hospital Care for English Speaking Residents of the Riviera

The Victoria Memorial Hospital, Mt. Boron, France, is built high over the sea wall a few kilometers beyond Nice on the road to Villefranche. It is on the main road where the busses and trams that ply between the Riviera towns pass at regular intervals. The sea below is like a clear blue glass bowl, surrounded by hills. White surf froth borders the edge of the blue while colorful Nice curls about the rim on the right.

Victoria Memorial Hospital is a small hospital unique not only for its marvelous scenic setting but for its service to the scattered English speaking population, English and American, from all the Riviera resorts that reach from Hyeres near Marseilles over the border of Italy to San Remo and San Raphael. Patients are brought by motor or train from Nice, Cannes, Monte Carlo and Mentone, Antibes, Grasse and from the hills of the Esteral. It is an oasis in a desert of strangeness to those who are ill and naturally wish to be cared for by doctors and nurses who speak their own tongue.

There are forty beds in the main building and six in a small building for contagion, divided into private, semi-private and ward spaces. There is a staff of specialists, both English and French, but all English speaking. The hospital is governed by a committee of eight drawn from English residents of the Riviera.

The nursing system is well worked out to fulfill the needs of the scattered community it serves by a method that could, if adapted to American conditions, prove of great value in certain sections of the United States where the problem of nursing care in the small community hospital has become difficult.

The hospital has no training school but brings over from England thirty or more nurses, registered graduates of accredited hospitals, as necessity indicates. These nurses are on a yearly salary and are under the direction of the matron in the same manner as student nurses would be. When needed they are sent out on special duty to the Riviera towns and work in the hospital when not so occupied. The head nurses remain stationary. The nursing details of the hospital that do not require their skilled hands are accomplished by salaried trained attendants.

The housekeeping department is administered by a registered nurse who ranks third on the nursing staff. Her assistants are gentlewomen who have taken training in domestic economy and who wear a special uniform. They do the cooking and serving with the assistance of necessary maids and are distinguished from the maids by the title of lady cooks. They occupy the same quarters and dining room as the staff of registered nurses.

A New Skyscraper Hospital and the Miracle of Its Building

By MAURICE DUBIN

Superintendent, Mount Sinai Hospital, Philadelphia

DURING the past year in several Eastern cities, the attention of the public and community has been repeatedly directed, by columns and at times by pages of space both in news items and paid advertisements in the newspapers, to the remarkable plans of large department stores in these cities to enlarge and rebuild while at the same time they maintain a complete merchandising service for their customers.

A Philadelphia store engaged in such a program, by posters and construction models as well as by advertisements, has been constantly focusing the attention of the public on the tremendous architectural, engineering and administrative problems involved in such an enterprise. Yet, during all the time that the press, the radio, the telephone and the telegraph were kept busy to tell the public of the tremendous achievement and of the difficulties and complications involved in con-

tinuing to sell the public its hats, shoes, vanity bags and radios, Mount Sinai Hospital, Philadelphia, quietly, modestly and without fanfare of trumpets, reconstructed and rebuilt itself into a modern hospital plant for 300 patients, with a new and well equipped out-patient building, while at the same time it continued to serve and treat 150 patients and to give more than 60,000 treatments to out-patients.

Hospital folk, however, who are accustomed to meet daily emergencies and difficulties calmly for fear of alarming their patients, and who, because the hospital is part and parcel of the medical profession, with its training and associations which teach its devotees to work quietly, are inclined to "hide their light under a bushel," will readily understand how and why two similar programs are being completed with such vastly different methods of recording the achievements. Because of the



Attractive furnishings feature the patients' lounge on each floor, Mount Sinai Hospital, Philadelphia.

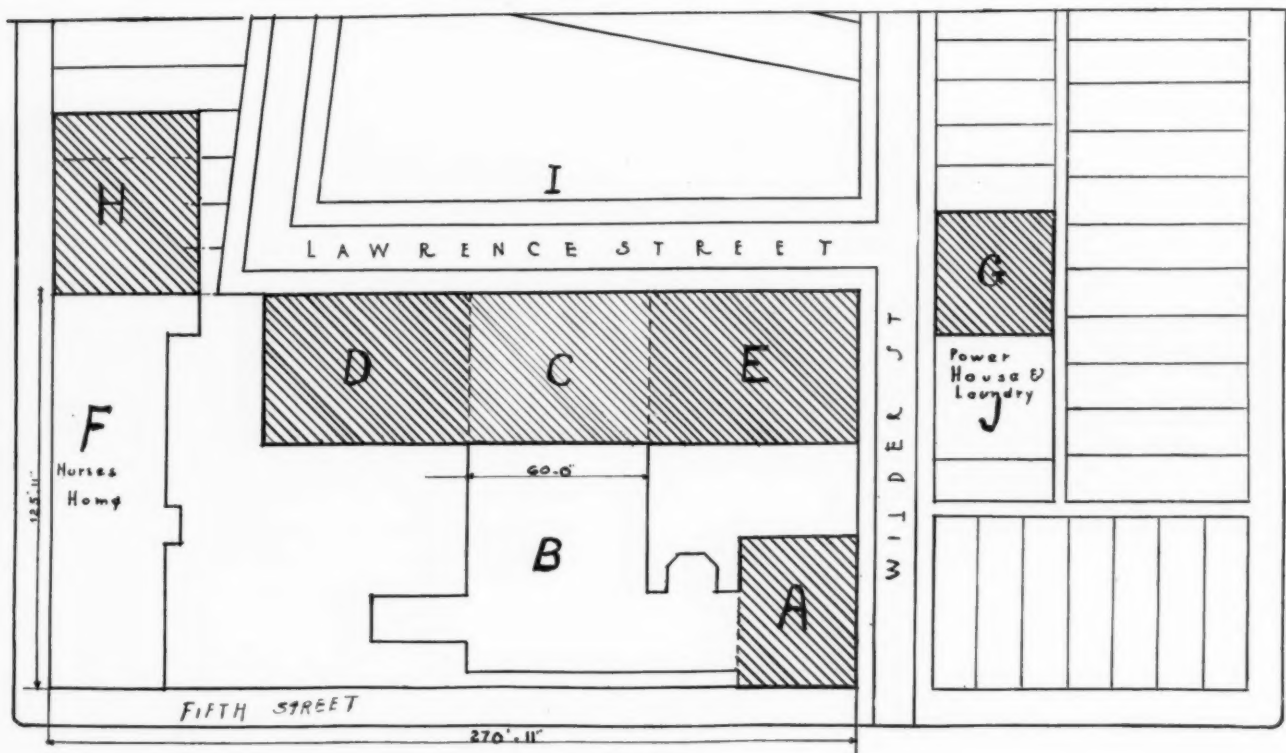
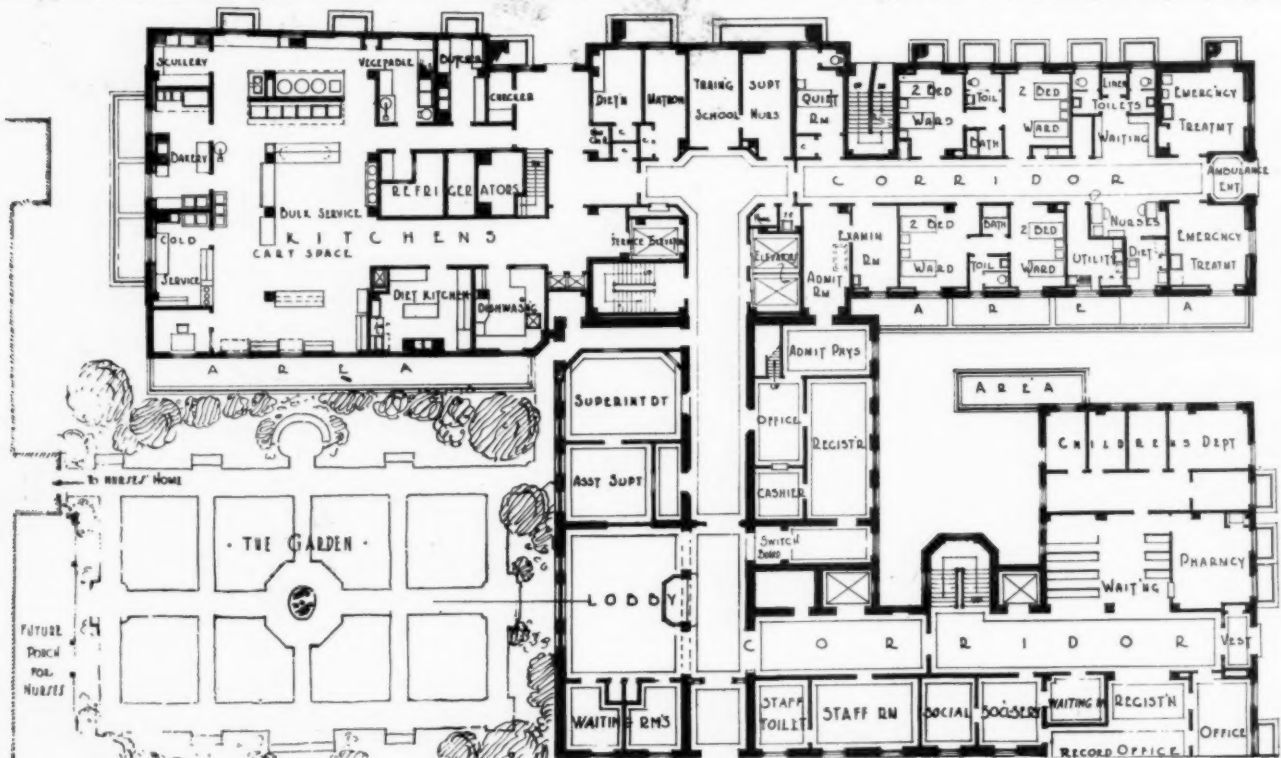


Fig. 1.

great expansion now taking place in the hospital field, and in view of the fact that so many hospitals face the problem of building additions and reconstructing existing buildings, the background of the problem that was involved in reconstructing Mount Sinai Hospital is presented here.

Mount Sinai Hospital stands in the southeastern part of Philadelphia, in the older and poorer

section of the city. In 1900 an old furniture factory building on the northeast corner of Fifth and Wilder Streets was remodeled into a twenty-five bed-hospital building. Through a series of additions, by 1925 the hospital had 150 beds, an out-patient department that gave more than 50,000 treatments a year and a complete modern nurses' home and training school building, shaping up as



Plan showing the arrangement of the first floor and hospital gardens.

shown on the block plan outlined in Fig. 1. In this diagram, Section A shows the location of the original hospital building, Section B, the later hospital addition, Section C, hospital additions including the Lipkin Dispensary building, Section F, the nurses' home and Section J, the power house and laundry.

In 1926, following a successful general building fund campaign conducted by the Federation of Jewish Charities to enable some of its constituent institutions to build extensions and to replace old nonfireproof buildings that had become both inadequate and dangerous, the hospital board decided to proceed with a building program. The prime object of this program was to replace the old hospital building, which contained such important adjuncts of hospital service as administrative offices, receiving and accident departments, operating rooms, kitchens and dining rooms and children's departments, by a new building that would house these functions adequately and safely.

At this time a movement was started by the Federation of Jewish Charities to combine the Jewish maternity Hospital, situ-

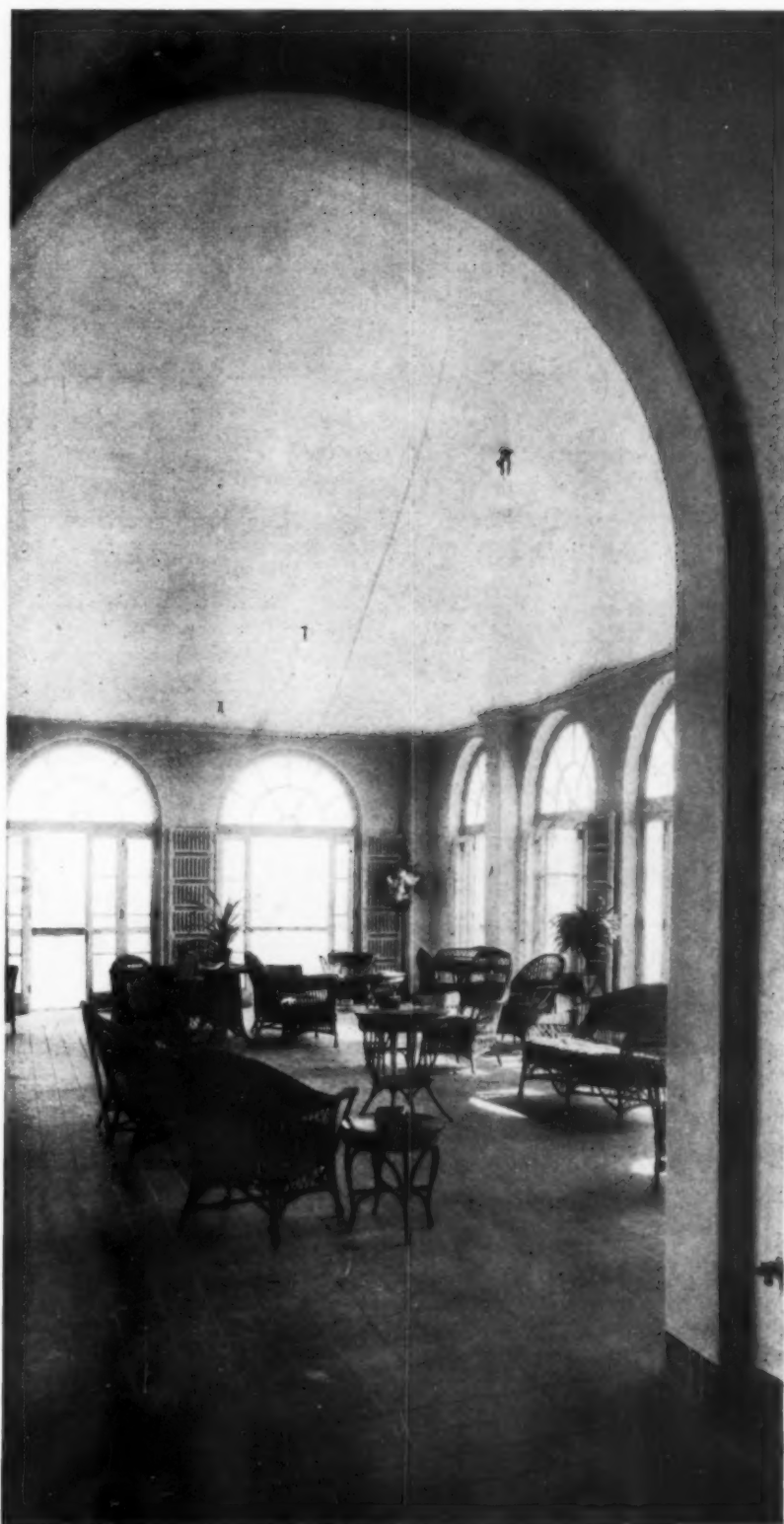
ated near by and serving the same neighborhood, with the Mount Sinai Hospital. It was felt that one well rounded institution would reduce the overhead of operating two institutions and the added expense of two separate building programs. The Maternity Hospital had also planned an addition and renovation of its plant as a result of an allotment from the general campaign fund.

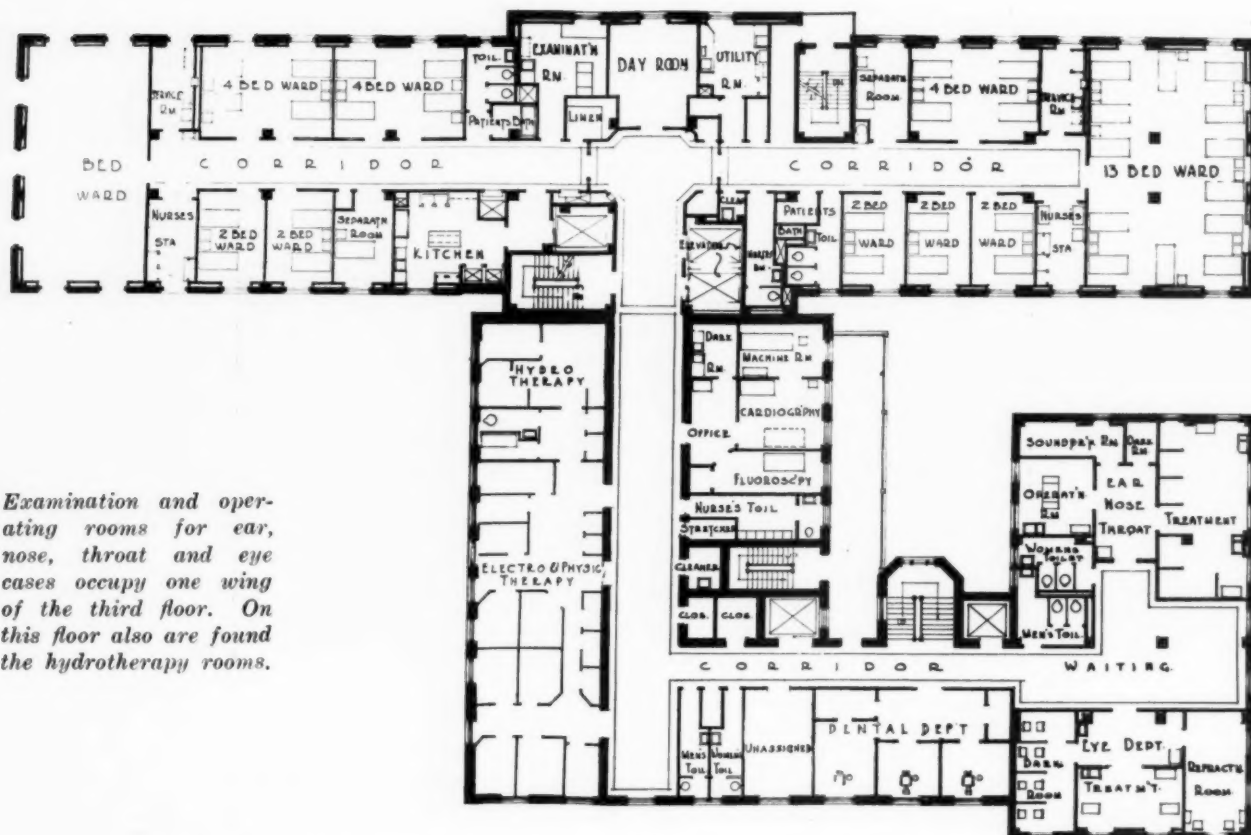
The boards of both hospitals agreed to combine the two hospitals and they accordingly secured the services of Dr. S. S. Goldwater, consultant, New York, and Magaziner, Eberhard and Harris, architects, Philadelphia, who were commissioned to study and work out the following program:

1. To plan an addition to the hospital of 100 beds that would provide fifty beds for obstetrics and give the hospital a capacity of 150 beds for ward patients, 100 for private and semiprivate patients, fifty bassinets for infants in nurseries and, included in the 150 ward beds, twenty-five beds for pediatrics.

2. To provide an adequate building for out-patient work.

Spaciousness is featured in the Mount Sinai Hospital solariums.





Examination and operating rooms for ear, nose, throat and eye cases occupy one wing of the third floor. On this floor also are found the hydrotherapy rooms.

3. To provide adequate facilities for all laboratories—clinical, pathological, x-ray, electrocardiograph and dental—and also for special therapies such as physiotherapy, electrotherapy, hydrotherapy and heliotherapy.

4. To provide the necessary additions to such service buildings as the power house and the

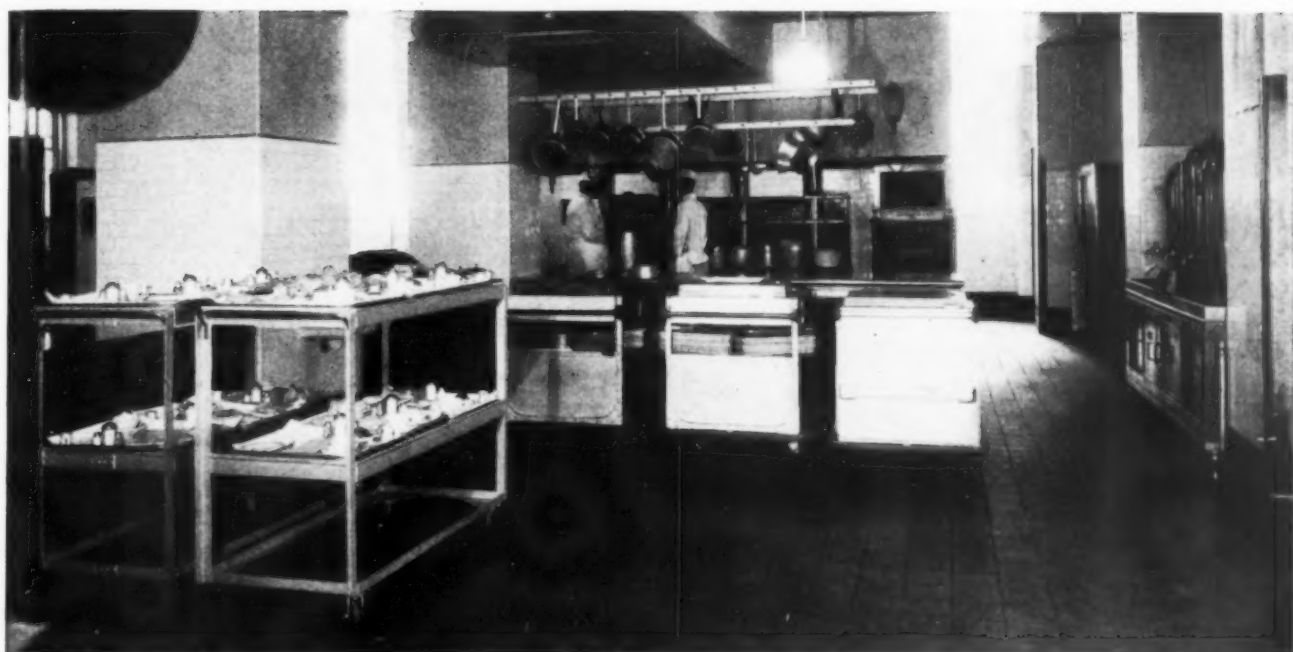
laundry and to living quarters for residents as well as for some of the hospital staff and personnel.

5. To confine the buildings to the plot available, as indicated in Fig. 1, and the costs to \$1,100,000, the maximum sum available.

6. To plan the buildings and program in order



One of the operating rooms, with a glimpse of the Delaware Bridge through the windows.



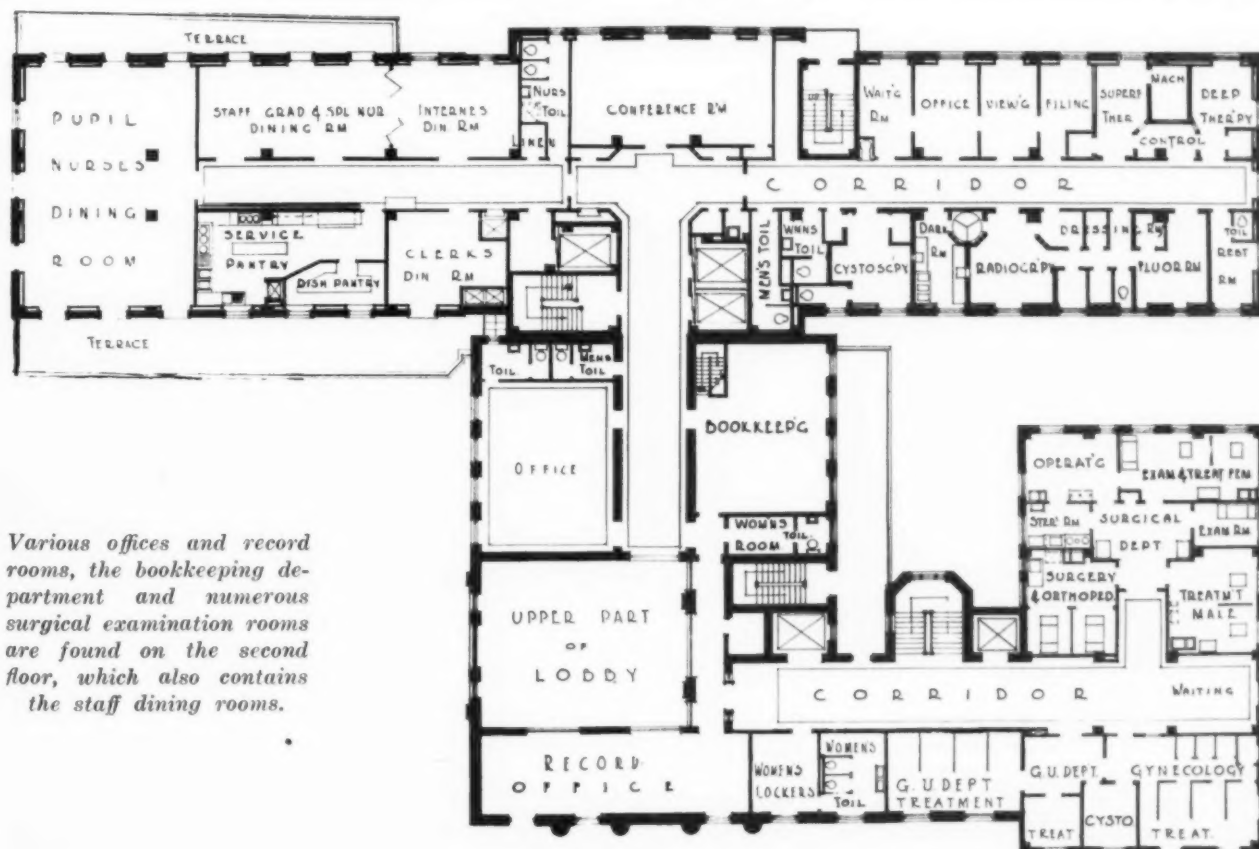
A corner of the chef's domain.

to enable the hospital to continue its service in all departments. It was felt that the out-patient service must be maintained and that there should be no reduction in ward service. The hospital board thought the needs of the neighborhood made this provision imperative.

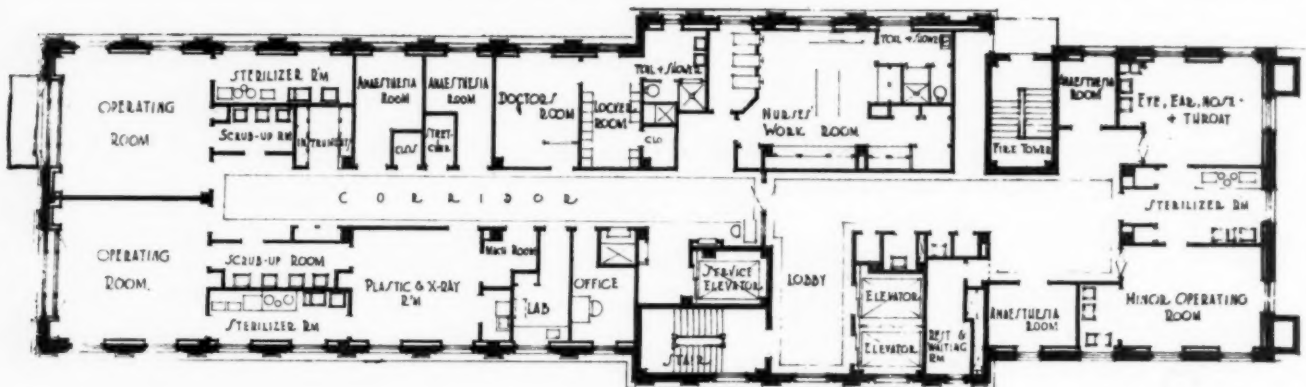
After considerable study and conferences with the board of trustees, the building committee of

the board, the general building committee of the federation and the medical staff, the consultant and architects presented a plan that they felt would meet all of the requirements. They proposed in a three-stage operation the following:

First, to build an addition to the power house and laundry, Section G, in which to place the refrigerating plant and other utilities occupying the



Various offices and record rooms, the bookkeeping department and numerous surgical examination rooms are found on the second floor, which also contains the staff dining rooms.



A nurses' workroom is one of the features of the ninth floor.

site of Section E, and to convert the row of houses on Plot I, for temporary use as a dispensary building into which could be moved the clinics housed on the ground floor of buildings in Sections C and B. This temporary dispensary building was to be so arranged as to make it subse-

street to the rear, shown in Fig. 1, is Lawrence Street. It is practically devoid of traffic, runs only one block and is surrounded by hospital properties.

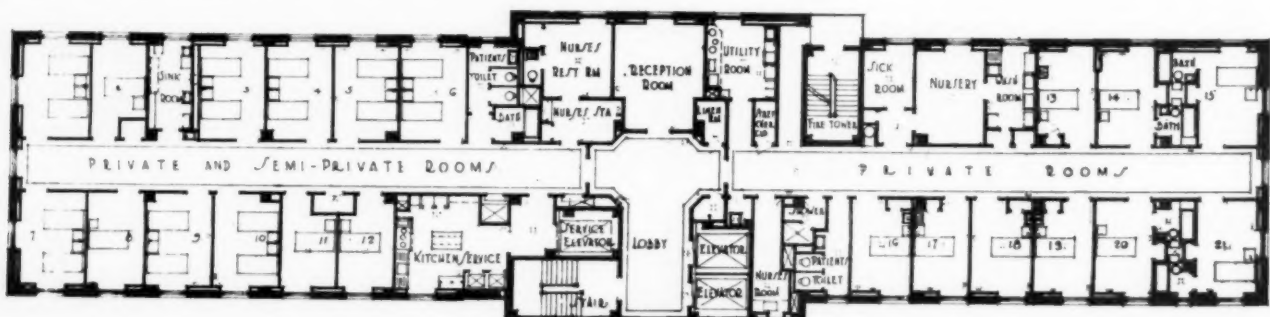
This ten-story addition was to contain in the basement, storerooms, linen room, mattress storage and sterilization rooms, help's locker and rest rooms and help's cafeteria; on the first floor, kitchens, some executive offices and accident and receiving departments for patients; on the second floor, staff and nurses' dining rooms, arranged for cafeteria or waiter service, and the x-ray department; on the third and fourth floors, men's and women's medical and surgical wards, respectively; on the fifth floor, ward maternity floor nurseries, delivery rooms, preparation and labor rooms and also a complete self-contained unit for septic cases; on the sixth floor, private and semi-private maternity patients' rooms; on the seventh and eighth floors, private and semiprivate patients' general hospital rooms and solarium on the southern exposure of the eighth floor, arranged with quartz glass and an open roof section for heliotherapy; on the ninth floor, operating rooms with two rooms for major surgery and separate rooms for cytoscopic work, plaster work and septic cases, two separate rooms for ophthalmological, otolaryngological and bronchoscopic work, a central surgical supply and workroom, anesthesia rooms, supervisor's office, laboratory for frozen section tissue work and



Fourth floor plan.

quently available as a dormitory and home for the resident physicians.

Second, after demolishing the two-story extension, Section C, and the service buildings and dormitories in Sections D and E, to erect on the site thus created on a plot 200 feet by forty-four feet, a ten-story building that would house the patients. This would also place the patients on a site away from the traffic noises on the Fifth Street front of the hospital. The small



How the private and semiprivate rooms are arranged on the sixth floor.

other quick determinations necessary during operation, surgeons' and nurses' dressing rooms, showers, lockers and lounge; on the tenth floor, open roof solarium and lounge for patients and an apartment for the superintendent in the penthouse on the roof.

Following the completion of this ten-story addition, the plan was to move the hospital departments into it, using the accident and receiving departments on the first floor for temporary administrative offices and the fifth and sixth floors—the maternity floors—temporarily for such features as therapy departments and laboratories which would probably be located eventually in Section B.

Third, to remodel Section B and arrange in it administrative quarters and laboratories and special therapy departments central to the hospital departments and the out-patient building to be placed on Section A when the old original hospital nonfireproof building was demolished. In the building on Section B, which was fire-resistive and required only remodeling, an impressive mezzanine and lobby with an entrance through the Fifth Street front were to be built. Around them on the first and second floors were to be grouped the administrative offices, record rooms, social service offices, staff rooms and waiting rooms; on the third floor were to be the physiotherapy, electrotherapy, hydrotherapy, electrocardiograph and dental departments and laboratories; on the fourth floor, the children's department, placed in a separate section from the other patients and having easy access to existing open porches with a southern exposure; on the fifth floor, the clinical and pathological laboratories with the animal house on the roof.

Buildings Are Connected

All of these features in this building in Section B would be central to the main hospital building to the east of it and to the out-patient building to the south of it. The out-patient building in Section A would connect with both of these buildings on each floor level and have a separate entrance on Wilder Street. In the basement of the out-patient building, connected by a tunnel to the main hospital building and laundry and power house, were to be the morgue and autopsy room, the drug laboratory and workroom and the record storeroom; on the first floor, the dispensary and social service offices, waiting lobby, drug room and children's department; on the second floor, the surgical departments, gynecological departments and genito-urinary departments and waiting space; on the third floor, ear, nose and throat and eye departments and waiting space; on the

fourth floor, various medical departments and subspecialties and waiting space; on the fifth floor, clinical conference rooms convertible into an auditorium for staff meetings, health lectures and demonstrations to the public.

When these plans were submitted, it was of course realized that they met the requirements, particularly as to the method of attack and approach to the complicated problem of keeping service going while literally building and rebuilding around the hospital. As one of the patients observed, it presented an illustration of the proverbial statement of "lifting oneself by one's boot straps." This solution of the problem, coupled with the fact that the estimates indicated the cost would be within the sum stipulated, gained the approval of the board of trustees. Accordingly, this Spring witnessed the completion of this novel and interesting undertaking which was started in January, 1928.

Plant Is Compact and Complete

Mount Sinai Hospital is now a compact, efficient, complete hospital plant, with a central administration service building, and the hospital and out-patient buildings under one roof, yet separate, with exactly the right degree of isolation. The centralization idea was further carried out within the hospital itself by placing the kitchen central to the employees' dining rooms below and the staff dining rooms above, and also by arranging for the possibility of central food service for the patients by two dumb-waiters and a service elevator connecting the kitchen with the patients' floors. To provide for any changing ideas as to the decentralization of food service in the future, the serving pantries are equipped with outlets for steam tables, dishwashing machines and similar equipment. A central surgical supply and dressing room from which all surgical supplies and dressings and dressing trays for operating rooms, delivery rooms and patients' floors are sent out further carries out the centralization idea as does the central linen room in the basement, which stands near a service elevator and the room that receives the soiled linens through a chute.

A few other details worthy of mention are the ward arrangements. Each ward floor is arranged in two divisions of twenty-four beds each. Central to both units are a day and reception room and a writing room for convalescing patients, an examination and treatment room, and a service pantry and general utility room. These are just off a central floor lobby and serve both units on either side. Central to each ward division of twenty-four beds, are a nurses' station and sink

room for bedpan service. A ward division consists of one single room for critically ill or moribund patients, two two-bed rooms, two four-bed rooms and one large eleven-bed room. The smaller room units in the ward division have glass insets in the corridor wall. These permit nursing observation and control and yet afford the patients privacy. These smaller rooms are used for very sick patients who require intensive nursing and other care and they also permit other advantageous grouping of patients.

The larger ward is used for convalescent patients who require the care of an attendant rather than of a nurse. This enables the hospital to concentrate nursing service where it is most needed. The private and semiprivate rooms are perhaps somewhat smaller than the average, but they are reasonably priced and are intended largely for the care of the middle class patients. It is the intention of the hospital to maintain its present schedule of rates, ranging from \$5 to \$8 a day, this to include practically all laboratory work, other than the x-ray. At every bedside in the hospital, provision is made for earphone radio service, with a choice of each of two programs. Convenient outlets are provided, with wiring to the electrocardiograph station, making it possible to take tracings from the bed if desired. Outlets for portable x-ray equipment are also provided.

Teaching and Research Room Provided

In giving what might seem to be a great deal of space to the various laboratories, there has also been taken into consideration the fact that these departments should have ample space not only for the routine work but for research and teaching. The hospital is doing a good deal of work in training laboratory technicians as well as students, nurses and physicians. To prevent complications in future planning, a comprehensive plan for future additions has been worked out, with provisions for additional buildings or pavilions to the east of the present site. The present service utilities, such as kitchens, operating rooms and laundry, have been planned to take care of a proportionate percentage increase in the number of patients to be served.

Architecturally, the exterior of the hospital presents a pleasing sight, the architects having fully taken advantage of the piling up of masses in the modern towering setback manner, made possible by combining a ten-story unit with two existing five-story units by which it is offset. This also gives the utilitarian advantage of open roof spaces on the offsets. Since the entire surrounding neighborhood consists of the typical small

two-story Philadelphia houses, the hospital itself by comparison looms as a veritable skyscraper in the neighborhood.

In this achievement it has been demonstrated that what at the outset appears to be a complicated and possibly insolvable problem, can become an asset by virtue of its very challenge to the mind and imagination of those concerned in an enterprise. Certainly, in this instance there has been evolved a more satisfactory health plant than would perhaps have been possible had the paths been easier and the roads smoother for planning.

Publicity Program at the Chicago Tuberculosis Sanitarium

Publicity is featured as one of the main functions of the Chicago Municipal Tuberculosis Sanitarium, the *Bulletin* of the sanitarium reveals. The publicity department is composed entirely of members of the sanitarium staff, and the entire field force has been converted into a great publicity staff.

The release is written at the central office. The features of newspaper publicity, such as topical interest, timeliness, good headlines, human appeal are incorporated. The release is then submitted to the board of directors for approval. It is then mimeographed, 200 copies made and the requisite number of copies sent to each dispensary. The head nurse next turns over to each publicity representative the number of copies needed for her news editors. The publicity representatives have been chosen with a view to their particular qualifications for the task. For instance a German editor is approached by a German nurse; a Swedish editor by a Swedish nurse or an Italian editor by an Italian representative.

The extensive campaign of publicity, followed at the sanitarium within the last two years, has brought definite results, the bulletin says.

Protecting the Child in the Tuberculosis Clinic

In the careless arranged or conducted tuberculosis clinic, the child who sits next to the coughing open case must be considered in danger, according to the *Bulletin* of the Chicago Municipal Tuberculosis Sanitarium.

"It is futile to say that the educated consumptive is harmless," the bulletin continues. "What if he does cover his mouth as he coughs? If one observes closely it will be found that he places the napkin to his lips a fraction of a second after he has coughed. The maneuver is well executed but too tardy; the bacilli are in the air.

"The clinic should be so arranged that there is little contact between the child and the open case or the suspect case.

"In addition to the physical arrangements the dispensary personnel should be trained to give the right of way to the open case. He should be sent from the waiting room to the special dressing room to the street in as rapid sequence as is compatible with efficient treatment and management."

The Qualified Administrator and His Problems

By E. E. SHIFFERSTINE, M.D.

Medical Director, Coaldale State Hospital, Coaldale, Pa.

HOSPITALS began as charities for the poor. From the time of their appearance they have developed and multiplied to so great an extent that to-day they are regarded as an absolute necessity, their service being the sole factor that has justified their existence and their tremendous growth. The service which, in the beginning, was limited to one class, is to-day extended to all classes of society. The value of that service it is impossible to overestimate—it cannot be measured in terms of dollars alone.

To-day hospitals are being looked upon as a great national industry, existing for the purpose of ministering to the physical needs of suffering humanity. In that industry several billions of dollars are invested in this country. In the State of Pennsylvania there are 167 state owned and state aided medical and surgical hospitals, and 22,000 beds, representing an investment of \$56,000,000, the annual cost of maintaining which is \$21,000,000 and a daily cost of \$56,000.

The question has often been raised, "What is wrong with our hospitals?" Complaints have frequently been made of ill-treatment on the part of administrative officers and members of medical and nursing staffs; of poor food and exorbitant prices. These complaints have generally proved to be without foundation, but occasionally they have come from sources that have led us to believe that there was probably an element of truth in them.

Patients Entitled to Consideration

The fact should always be borne in mind that it is for the well-being of patients that hospitals exist and that patients are entitled to be treated with the utmost kindness, consideration and respect. It should therefore be the constant aim of all hospitals, if they are to fulfill the great purpose for which they have been brought into being, to minister to the best of their ability to the needs of patients. To achieve this desired end, hospital affairs should be in the hands of those who are primarily interested in the patient. Personal interests, fads and fancies should always be subordinated to the interests of the hospital and its

patients. It is my belief that as a general rule hospitals are conscientiously striving to give their best and to comply with the standards required for recognition by the American College of Surgeons.

The policies underlying the administration must be determined by the board of trustees, and it is imperative that the members of the board realize their responsibility, and have a profound devotion to duty, in order to merit confidence. A board of trustees cannot, however, accomplish much that is really worth while without the services of an efficient superintendent. Therefore the relations between the board and the hospital's chief executive should be marked by cordiality, confidence and admiration.

Superintendents in Full Charge

Superintendents should have full authority in the administration of the hospitals with which they are connected. They should hire, discipline and dismiss employees and should have administrative supervision over the medical staff and the purchasing of supplies. They should be required to make suggestions on matters of policy and to take part in the discussion of policies. They should run the hospital without interference on the part of the trustees, and each month should furnish a report giving an account of the hospital service rendered and the cost thereof. Capable superintendents who have merited the confidence of the board are able to guide its policies to a large extent. It is the duty of the trustees to insist that the hospital is up-to-date in equipment and in operation; that the methods of the staff are progressive; that costs are kept at the irreducible minimum, consistent with the needs of the patient; that professional jealousy is not permitted; that the members of the staff comply with the rules and requirements of the hospital, and that unrest and discontent are not allowed to gain the slightest foothold, otherwise the hospital and the patient will suffer.

Apparently one of the greatest difficulties in connection with hospital administration is the staff. It is regrettable that there have been cases

of pronounced selfishness, jealousy and disloyalty on the part of staffs. Superintendents represent the boards. It is therefore their duty to see that the rules and regulations of the hospitals are strictly complied with and that the boards are kept informed of matters they ought to know. It is important that there be no division of authority; the superintendent must be supreme, next to the board of trustees.

The manner in which a hospital is kept reflects the character of the superintendent in charge. Some hospitals lack proper facilities; others are just getting along and do not seem to justify their existence; others, principally community hospitals, are lagging behind due to lack of community support, in addition to which their patients are not in a position to pay hospital bills owing to depressed industrial conditions; still others are totally unable to support themselves, which, if they are indispensable to their communities, raises the question as to the advisability of these being taken over by the state. Some hospitals should be consolidated in the interests of all concerned.

The success of a hospital depends principally on two factors, the importance of which cannot be overemphasized, namely, an adequate plant and an efficient staff in charge of a thoroughly competent executive. The reputation of a hospital depends upon the work it does, and in order to do the best work, it is of supreme importance that the hospital have at its head a highly trained, experienced executive, whose outstanding ability in his special field of service is fully recognized by the members of the staff, whose qualifications are respected and acknowledged by outside physicians and surgeons and in whom the community has the utmost confidence.

No Examination of Superintendents

It is a fact of more than passing moment that there is a board regulating the standard of medical education and licensure; that there are state boards of examiners for pharmacists, dentists, optometricians, osteopaths, veterinary surgeons, nurses, accountants, engineers and land surveyors, architects, mine foremen and even for undertakers, but that there is no board of examiners for registration of superintendents of hospitals, whose duties are manifold, exacting and of more than ordinary importance.

It is readily conceded by persons of average intelligence that the services of thoroughly competent superintendents are indispensable to hospitals worthy of the name, and because of the exacting demands that are continually made upon them, in fairness to the institutions they repre-

sent, in justice to the communities they serve and out of respect to themselves, persons should not be permitted to act in such important capacities, unless they have first demonstrated that they possess the requisite qualifications. Furthermore, the duties devolving upon superintendents are too important to be intrusted to superannuated professional men, who have to a large extent outlived their usefulness; or to retired business men, whether they have been successful or unsuccessful; or to clerks, no matter how efficient; or to nurses; or even to doctors unless they are possessed of the essential qualifications.

Hospital Training Lacking

In twenty-eight out of forty-four hospitals I recently visited, the superintendents, prior to their appointment, had had no experience whatsoever of hospital work; in the other sixteen the superintendents had had experience in some position or other in a hospital, but none of the sixteen had had any experience as an executive. To command the respect of the staff, superintendents should be intelligent, alert, tactful, and should have a thorough conception of the professional work to be done. They should grasp the importance of their relation to the hospital and the community they serve, which is a matter of vital significance. They should be able to secure the necessary funds, and by virtue of their ability and personality to command the respect, confidence and cooperation of the community.

How are persons with the qualifications mentioned to be secured? Would not the American Hospital Association be rendering a service of real value by suggesting the creation of a board to fix a standard of requirements to be met by all candidates for such positions? The next question that naturally arises is, "How is such knowledge and experience to be acquired?" A college course for executives is being suggested. I doubt the wisdom of this. Without seeking in the least to minimize the value of college courses, it seems to me that persons aspiring to such important positions should first of all demonstrate a natural inclination as well as aptitude for the work involved and in addition should display willingness to enter upon and perform the many exacting duties connected therewith.

Practical training and experience gained under the guidance and direction of capable and successful superintendents are, I consider, of infinitely greater value and importance than would be a college course designed for executives, inasmuch as candidates would be required to acquaint themselves with the various phases of hospital work from the bottom to the top, under expert direc-

tion. Before, however, they should be admitted to such training they should be graduates of colleges of recognized standing.

As an incentive to candidates to qualify for such positions, adequate salaries should be offered. On my recent trip through the state, I was amazed to learn how miserably superintendents are remunerated for their services and the great reluctance displayed on the part of trustees to grant even insignificant increases. In assuming such an attitude, trustees are refusing to apply the rules and practices they employ in business when selecting heads of departments. This state of affairs is not exclusively confined to the great Keystone State, but is general throughout the country.

In the hospitals I visited, six superintendents received under \$7,500 (most of them less than \$6,000); eleven under \$5,000 (most of them less than \$3,500); twenty-four under \$2,500 per annum; many of them less than \$2,000, which is only slightly in excess of the yearly wages of the common laborer who works only eight hours per day, while the full-time superintendent is always on duty including Sundays and general holidays.

Many Duties Involved

One superintendent spent two hours, another only one hour, at the hospital each day, and the rest of the day at some other work. At another hospital one and the same person was acting as superintendent, dietitian, housekeeper, operating room supervisor and instructor of nurses. Three superintendents were compelled to resign because of inadequate remuneration. Several superintendents became greatly discouraged due apparently to lack of essential training. In two cases the title of superintendent was not adopted, despite the fact that these persons were acting in that capacity. Some superintendents were anxious for the recognition of their hospitals by the American College of Surgeons, but their staffs showed no sympathy in this matter, hence there was non-compliance with the requirements of the college, as well as with those of the state board.

I cannot too strongly depreciate the injudicious practice of paying superintendents niggardly stipends. Such a practice invariably reacts to the detriment of the hospital. It is false economy to engage unqualified superintendents and pay them ridiculously low salaries; on the other hand, it is real economy to engage superintendents of the highest type and pay them adequate salaries.

If superintendents of the caliber and training I have been advocating are to be secured they should receive compensation commensurate with the duties and responsibilities devolving upon them.

Furthermore, there should be placed at their disposal suitable living quarters situated on hospital property, easily accessible and at all times within call of the hospital. With regard to the nursing problem, nurses as a general rule like nursing; they are proud of their calling. Attending to the needs of the sick with the object of making them well appeals to them. When hospital nurses realize that they are active members of an important organization, and that, together with the other members of the staff, they are working together with the object of effecting the recovery of patients, that consciousness lends inspiration and dignity to their labor. Some of the hospitals I visited bitterly complained of having in their employ nurses who were disloyal, arrogant, more anxious to hinder than help, and who lacked an appreciation of faithful, willing service. The hospital is no place for such women. They are evidently moving in an environment with which they are not in sympathy.

I also found a great deal of resentment to what was described as the arbitrary and obstinate attitude assumed by the Bureau of Medical Education and Licensure and the Bureau of Registration of Nurses. If such complaints were only occasional their validity might be questioned, but when they are general and emanate from without as well as from within the hospitals, it is unwise to ignore them. These bureaus have unquestionably accomplished many things that are praiseworthy, but is it not possible that in their enthusiasm, they have gone to extremes in the matter of their standardization programs? As a consequence, many hospitals have felt obliged to object strenuously to certain rules and regulations formulated by these departments, on the grounds that such requirements are not necessary in caring for the needs of the community, and inflict a financial hardship on hospitals.

Legislation for All Hospitals

Are these bureaus justified in seeking to make all hospitals, not connected with teaching institutions, educational centers, and their laboratories, places for scientific investigation and experimentation, unless separate funds for such purposes are available and teachers specially trained are placed in charge? Hospitals are naturally interested in all legislation that concerns them. It seems to me that legislation should be made to apply to all hospitals, not merely to those that have come into the possession of public money and are thus better situated financially. The small hospital has its place, and its rights should be fully recognized and respected. The small hospital is vital to the community it serves, and its value to

the commonwealth is acknowledged as inestimable.

The average hospital with fifty to seventy-five beds is usually sufficiently equipped to train women in the fundamentals of nursing, and to prepare them to enter schools for special work. They are also able to give the intern all the practical experience essential to the general practice of medicine.

Standardization should be balanced with common sense. Is it not possible to set the standard so high as to defeat the very purpose in view, and may not the effect of excessive standardization be felt even beyond the confines of the state?

Hospital executives, as a whole, will no doubt agree that all staffs should be composed, as far as possible, of full-time physicians and surgeons who are expert in their respective branches, and that "courtesy" and "open" staffs should not be given the slightest consideration. There is nothing that upsets the morale of an institution so much as "courtesy" and "open" staffs, consequently hospital staffs should be closed.

This seems to be the consensus of opinion of those who have had experience of such staffs. Privileges have, no doubt, been granted in the past to "courtesy" and "open" staffs from the standpoint of financial advantage, and they have been used as a means of deluding patients into believing that they were receiving a high quality of medical and surgical service.

Care Needed in Selection

Too much emphasis cannot be placed on the necessity of exercising the greatest care in the selection of hospital personnel. The extent to which staffs should be "carried" is a matter to be decided by the individual hospital, on the basis of community needs and hospital facilities. To assume that a general practitioner who enjoys a large and remunerative practice is qualified as a staff officer is a colossal mistake. To permit general physicians to assist at operations on all patients referred to the hospital by them, at the expense of a regularly appointed assistant or intern, is a practice fraught with many dangers, and should not be countenanced. To tolerate such a practice lays the hospital open to criticism, and raises the question as to whether the reasons for acting thus are ethical and nonmercenary.

We are all naturally profoundly interested in the activities of the hospitals with which we are connected and are anxious for their success and steady progress. But in our enthusiasm for our own particular field of activity, we are apt to overlook many matters of great importance, the principal of which in my judgment is the uniform

progress of hospitals as a whole. In our great state there are hundreds of institutions vitally concerned in ministering to our health and social welfare. They represent many millions of dollars. Should we not therefore, with a view to securing greater uniformity and progress, consider the advisability of requesting the legislature to create in the governor's cabinet, a department of hospitals?

This department could operate with an advisory board composed of qualified hospital executives, the duties of which would be the general supervision of all hospitals (without detracting from the powers of the local administration with which it must not in any sense be confused); the adoption of rules regulating the erection, establishment, uniformity and progress of hospitals in all their basic activities, and could be responsible for legislation affecting the general good of hospitals. Furthermore, because of the close relationship between hospitals and public health, might not power to enforce legislative measures enacted in the interests of public health also be delegated to this department? I believe such a move would be of immeasurable economic value, both to the state and to the individual hospital.

London Foundling Hospital Soon to Exist Only in Memory

The brick and mortar shell of the Foundling Hospital, London, is now being carted away by the housebreakers. The building will soon be but a memory, and its site a name. But its fame will outlive Newgate and Tyburn.

On October 17, 1739, George II granted a charter for the Foundling Hospital and a year later a house in Hatton Garden was opened. But it was not until 1746 that the first wing of the Foundling Hospital was opened up.

Unwanted children abounded all over the country. Carriers conveyed them from their "homes" to the hospital at a certain price a head. It is said that the charge for bringing children from York, packed into panniers, was eight guineas a trip. But competition soon reduced the profits, and, to make a little extra, the carriers sometimes stripped their charges before they laid them on the steps of the hospital.

A sidelight on the sufferings of the poor in the "good old times" is given when we learn that to save the parish funds, poor law officials themselves sometimes dropped pauper babies into the foundling basket, or frightened unmarried mothers into abandoning their children.

In 1756 the government voted the foundation £10,000 on condition that it receive children under a certain age without condition or inquiry. Under the flood of admissions that immediately took place the organization of the hospital broke down completely. Of the 15,000 children received under this arrangement less than 5,000 survived to be apprenticed. The rest perished from hardship and neglect in the early days of their adoption.

Not until the beginning of the nineteenth century did the governors of the Foundling Hospital learn the most efficient way to administer their charity.

Financing the Hospital Laboratory

By ROBERT A. KILDUFFE, M.D.

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THE development of the hospital laboratory in accordance with the requirements of the hospital standardization program has naturally been accompanied, especially in the case of the smaller hospital, by some complications, not the least of which is the question of how the laboratory shall be financed.

The requirements of the approved hospital laboratory necessitate something more than a place of sorts in which various laboratory procedures may be carried on, and a more or less competent and partially trained lay technician to do the work. This sort of laboratory and this sort of laboratory worker are as much behind the times as the saddlebags of the old-time practitioner.

The hospital desiring a place on the list of hospitals approved for intern training must have a clinical laboratory worthy of the name, adequately equipped, sufficiently manned to carry on the work and efficiently directed by a competent clinical pathologist. This pathologist should be a physician who has had not only adequate clinical experience but a minimum of three years of specialized training in his specialty.

Like any other skilled physician specializing in

any other branch of medicine, the clinical pathologist should receive adequate compensation, especially in view of the relative shortage of workers in this field. Moreover, like other men whose skill and ability in their chosen field increase with experience, he has the right to expect that as time goes on his income will advance in keeping with the growth of his ability and reputation.

Until rather recent times the hospital laboratory was, as it were, the Cinderella of the family. Located usually in dusty corners or forgotten burrows not wanted by any other department, its personnel and equipment increased and amplified only after struggle and difficulty, it was all too often regarded as a liability rather than an asset.

The natural and inevitable result of such a situation was a consistent endeavor to keep the laboratory expense as low as possible. To some extent, especially in small hospitals, this reluctance to expend money on the laboratory still obtains.

Considering the amount of money invested in the hospital plant and required for its running, the yearly turnover of the business, and the highly complex and technical nature of the work carried on, even in the hospital of moderate size,



The laboratory at the National Home for Disabled Volunteer Soldiers, Soldiers' Home, Los Angeles County, Calif.

it is surprising that boards by whom the destinies of the institution are more or less controlled are so often composed of individuals without any particular skill or adaptability for conducting so vast an organization.

It is somewhat peculiar that as a rule the physicians who comprise the hospital staff, who utilize the technical plant and who thus know best its needs and deficiencies are so seldom represented on the board of directors.

This being so, it is understandable why the hospital in which the clinical laboratory is a disgrace often has an x-ray department whose equipment is admirable, for the x-ray apparatus emits visible sparks and audible noises in its operation and has a most mysterious film or plate to exhibit as a result. The clinical laboratory, on the other hand, is a quiet place of unimposing appearance and has only a report or a slide to show for its labors, the value of which is a matter often beyond the comprehension of the board.

The same psychology may account for the fact that seldom indeed is the clinical laboratory the startled recipient of gifts or endowments for its individual use.

Financing Is Problem

The hospital board and the hospital staff eager to establish an efficient laboratory and conscious of its importance in the development and maintenance of general hospital efficiency, are all too often confronted with the specter of expense and are at a loss to know how the laboratory shall be financed.

In the absence of specific endowment the laboratory income can come only from two sources, within or without the hospital.

We may consider, first, the income to be derived from patients in the private rooms and private wards.

"Piecework" charges have been quite commonly resorted to and are often a source of dissatisfaction because desirable laboratory examinations will not be asked for when the attending physician feels that the patient cannot afford the added expense, the responsibility for which will be laid on his shoulders. Such a plan often works, therefore, to the disadvantage of the patient, in that he is thereby deprived of the advantages of the scientific study for which the hospital often receives him.

A flat charge, on the other hand, may be entirely too much for the work done on one patient and entirely inadequate for that done on another. Neither of these plans, then, is entirely successful or without objection.

The object in view of course, is to arrange, if

possible, that the laboratory income and outgo shall be within speaking distance of one another.

The plan here described is feasible and in some measure disposes of the objections noted above.

It is based upon the following assumptions: In a general way, the laboratory work done after admission is asked for either as an aid in making a diagnosis or to confirm a diagnosis already made. In some cases extensive study may be required; in others, one or two laboratory examinations may suffice.

Once the diagnosis is made subsequent laboratory examinations are related either to a study of the progress of the condition, the confirmation of the diagnosis, as in the case of bacteriological or tissue studies, or to aid in detecting complications.

If these premises are granted, it may be assumed that upon the entrance of the patient into the hospital the attending physician will have in mind such laboratory examinations as are most applicable to the situation, or these may be selected in conference with the laboratory director.

This being the case, it is then feasible to establish a flat fee for the initial laboratory work, varying in accordance with the daily or weekly rate paid by the patient, the amount to be settled upon by the individual hospital, taking into consideration the cost of the laboratory in general. For example, the fee might be set at approximately 20 per cent of the weekly rate in question. A patient in a seventy-dollar room would pay, therefore, a fifteen-dollar entrance laboratory fee, while a patient in a two-dollar per diem ward would pay five dollars. Moreover, this fee would include any or all laboratory examinations requested by the attending physician within the first twenty-four hours after admission. After this such further examinations as are required by the exigencies of the particular case are charged for separately.

Plan Ensures Definite Income

Under this plan there can be no reason for incomplete initial study of the patient nor can there be just complaint by either the patient or physician. Such later examinations as are made and separately charged for will then be made, not "to complete the record," or to create a pseudo-scientific atmosphere, or for any other reason than that they are necessary for the careful study of the patient and his condition and therefore are not justly open to criticism.

Although such a plan may not, and probably will not fully sustain the cost of the laboratory, it will at least assure a definite laboratory income with the least possible complaint from all concerned.



The laboratory at St. Mary's Hospital, Wausau, Wis.

There has been considerable discussion as to whether the hospital laboratory should do work for patients not in the hospital. On the one hand, it is said that by so doing the hospital enters into unjust competition with the clinical pathologist maintaining his own laboratory. On the other hand, hospital salaries seldom being of startling proportions, the clinical pathologist in the hospital as a full-time worker naturally feels that there is little reason for his being restricted to his salary as sole source of income.

In the last analysis there are two factors worthy of consideration.

Does the full-time laboratory director secure and hold his job because his ability is too mediocre to permit of his earning a living in any other way, or is he directing the laboratory because of his ability, reputation and attainments as a clinical pathologist?

Does the clinician select his laboratory solely because it exists as a mass of physical equipment or is he influenced by his knowledge or belief in the ability of the pathologist?

If the latter be the case, then quite naturally the staff physician is led to give his laboratory work to the hospital pathologist of whose skill he is personally cognizant and with whom he may easily discuss the interpretation of the result.

In other words, it is to be hoped that it is because of the pathologist himself, and because his ability and opinion are respected and held to be of

value, that the work comes to the hospital laboratory and not simply because the laboratory exists.

If, perchance, a pathologist spends half his time in the hospital and the remainder in his private laboratory, some of his work will come to him because of his hospital associations, and his hospital connection is therefore of value to him as compared to another pathologist in the same town who has no hospital affiliation.

If one man may work partly in a hospital and partly outside, it seems that another, spending all his time in the hospital, should be at liberty to derive personal benefit from the ability that put him there.

However, this is an individual problem and will remain so until the salaries paid hospital pathologists are commensurate with the income assured an equal degree of professional skill in other branches of medicine.

Where the hospital pathologist does outside work in the hospital laboratory the question arises as to the disposal of such fees. Shall they belong entirely to the hospital, entirely to the pathologist, or shall the hospital receive a pro rata share in return for the use of its equipment?

This, again, is an individual problem. If it is true—and it should be true—that it is the skill of the pathologist rather than merely the use of the laboratory that is sought, then there is little reason for the total diversion of such income to the hospital.

Can the Superintendent Be Corrupted?

By DONALD C. SMELZER, M.D.

Superintendent, Charles T. Miller Hospital, Saint Paul, Minn.

THE daily press of this country contains many references to persons occupying positions of trust who use their positions to benefit themselves in various ways by means of what is commonly called graft. This practice is prevalent in many city departments and in political strongholds.

A question now confronting those interested in the betterment of hospitals is just how much graft is going on in institutions and under what guise it is thriving.

Certainly not all of the 7,000 hospital superintendents and purchasing agents are dishonest, but there undoubtedly are some who lend themselves to shady dealings with certain hospital supply houses and firms catering to the needs of the hospitals. Perhaps in some instances this is done innocently, for in this matter the manner of approach is subtle and the inexperienced might not suspect at first that anything was amiss.

Supply House Methods Vary

Many methods are used by the supply house that would have you use its goods and is willing to corrupt you for that privilege. Some of these methods are crude, others are rather naïve, many are subtle and a few are skirting on the fringe of dishonest practice. Some of the incidents to follow are based upon personal observation, others have been gleaned from reliable sources and all can be substantiated.

Some time ago a salesman from an out-of-town hospital supply house called at a hospital and displayed his line. His samples were attractive, but the prices were high compared with those of other concerns with which the hospital had been dealing. The plausible fellow explained that if an order were received, the goods would be billed as listed, but that on receipt of payment, a special attractive discount would be offered, the check being made payable to the superintendent. This concern sells a lot of goods, especially to small hospitals, but to just how many superintendents a similar offer is made must be left to the imagination.

Certainly the above example is one of straight

graft. But is such a salesman any worse than the representative of a concern who hands out expensive presents? An incident is known of a hospital superintendent who was the recipient of an expensive fraternal ring from a suave salesman, who, on securing an order, promptly overcharged the hospital more than the cost of the ring. In this case the goods were ordered blindly without a quotation, the integrity of the agent being taken for granted. This is the type of salesman who finds out your hobby and pesters you with gifts, such as golf bags, fishing rods, presents for your wife or children—anything to put you under obligation and literally force you into giving him the business. The hospital in such instances always pays indirectly.

How about the salesman who called up one of his customers and informed him that he had just mailed him a check for \$200? On being asked the reason for this, he smoothly explained that he had "picked up a red hot tip on a radio stock, and knowing that you were interested in the market I took the liberty to put you in for ten shares. All I had to put up for you was a small margin with a broker friend and 'she' jumped twenty points in three days. The \$200 is your profit." Whether the stock transaction was ever made is only conjecture. The action of the superintendent is unknown.

Recipient Guilty of Graft

Is not the recipient of meat, poultry, canned goods, lumber, cases of fruit, expensive lingerie or silk hose from concerns catering to the hospital, either spasmodically or regularly, guilty of graft? If the dealer is honest with his prices and quality, does he have to, or can he afford, to donate such things to the superintendent or buyer?

Such practices as these, however, must not be confused with the so-called "good will advertising" which has recently come into vogue and which has no ulterior motive. Many reputable concerns are, especially at holiday times, buying and distributing to their regular customers, art calendars, art leather goods, desk memos and

paper weights, all plainly stamped or engraved with their names or trade-marks. This is legitimate advertising and although some of these souvenirs are expensive the reputation of the concern proves the spirit in which they have been given, and they are always sent to the office and not to the home.

In the past when hospitals were perhaps not so well administered as they are to-day, it was a common occurrence for them to receive a shipment of goods that had not been ordered. Sometimes these goods were unpacked and used before the invoice was received. Fortunately this type of merchant is practically extinct, but every now and again the practice crops up. Sometime ago a hospital received an unordered shipment of hot water bottles from an unknown jobbing house. These were invoiced at a seemingly fair price. Taking for granted that a mistake had been made a letter was sent to the concern, inquiring what disposition of the goods should be made. A reply was received that the bottles had been sent in error, but if they could be used they would be rebilled at a discount. Examination showed the goods to be of an inferior quality and not as represented by the invoice. This was undoubtedly a trick on the hospital and the "high grade" hot water bottles were promptly returned, "charges collect."

Dishonest Concerns Decreasing

Fortunately, concerns that resort to shady and contemptible practices, openly or indirectly, are decreasing in number, because many have gone bankrupt and others have grown poorer and poorer, instead of expanding their business and prospering.

There is still another menace to the hospital, especially the smaller hospital. This is the salesman and self-appointed consultant who has something to sell you in the line of equipment or merchandise and who persuades you that unless you order and install this article at once your hospital will soon be antiquated. It is true you might be able to use the apparatus or supplies very nicely, but you just did not put it in the budget and immediate funds are not available to pay for it. Then comes the high pressure sales talk, alluring statements, "pay for itself in six months," "can be bought on easy terms," "a small down payment and the balance spread over months or years." The salesman doesn't tell you the exorbitant interest rate that is discreetly hidden in the price, and he who buys will usually find that the balance due outlives the life of the article purchased. Many a hospital superintendent to-day is struggling to pay for goods his predecessor thus bought

without investigating either the goods or the concern.

For the past year hospitals large and small have been receiving alluring advertisements from a hospital supply house specializing in patients' bedgowns and other cotton goods. The preamble tells you about quality, and scattered throughout the folder are attractive pictures of radios, grandfather clocks, fountain pens and desk sets. Plainly stated under each article one reads: "Free with so many dozen bedgowns," or "Free with so many dozen operating room gowns." On comparing the prices with similar articles of other widely known and reputable dealers it is readily seen that the prices are higher. The above presents cost money and you can rest assured you pay dearly both for the gowns and the gift selected if you "fall for" this type of merchandising.

Hospitals Sometimes to Blame

Now, unfortunately, there is another side to this story and this time some hospitals must bear the blame. This is the promiscuous and unwarranted asking of money donations from ethical dealers in hospital supplies, when a new wing, service unit or nurses' home is planned. Is it fair to inform a concern that has served you faithfully and honestly that it is expected to contribute a large sum, and that failure to do so will result in the loss of the business? These concerns are selling to hospitals on a small margin of profit and if they contributed money for one they would have to do so for all, and would either have to raise their prices, which would affect all hospitals alike, or go out of business. Yet officials of several large firms have stated that they are constantly being asked for such donations and that they have had to lose the business to a competitor or arrange to cover this expenditure by increased prices or by altering the quality of their merchandise.

System Obligates Purchase

The open manner in which these demands are made should perhaps be classified as begging rather than as graft. It also obligates the hospital to buy from the concerns thus contributing, *ad infinitum*.

Other hospitals openly ask for unreasonable discounts—no paltry 5 or 10 per cent, but 40 and 50 per cent, on the ground that they are charitable institutions. No legitimate business can withstand constant drains such as these, and if this matter were properly investigated, it would be evident that the manufacturers are getting the money back one way or another.

Again, do not misconstrue the true philan-

thropy shown by large business concerns donating money to legitimate financial drives made by deserving institutions, institutions that are in every sense of the word charitable organizations. Such monies given to local hospitals are given in the proper spirit, with no thought of direct financial return. These concerns are proud of their hospitals and of their city, and they indirectly "reap where they have sown," and by maintaining prices consistent with quality they naturally get what business is coming to them. A good privately endowed charitable hospital is one of the greatest assets to a city and it is worthy of public support.

Petty Graft Affects Public

It is not hard to see how all this petty graft affects the public. Charges of inefficiency have been and are being made against hospitals. In the vast majority of instances these are untrue. Scandal, rumor, gossip and yellow journalism have been swallowed by a gullible public. A recent exposé of alleged graft giving and graft taking in a New York hospital has been played up by sensation seeking newspapers, and unfortunately so, because the information does not appear to be well founded.

It is time for the honest hospital people of this country to drive from their ranks the graft taking superintendent and from the commercial field the graft giving supply house.

If the Hospital Exhibitors' Association would establish a committee on ethics, with the power to expel members when evidence of apparent dishonest practices and underhand dealings is brought to its attention, and if this organization would withhold membership from concerns sanctioning graft giving under any guise whatsoever, the death knell of the guilty ones would be sounded.

At the same time, if the American Hospital Association would debar from membership the superintendent or hospital that solicits or accepts graft, much good would result.

The rules for the purchasing of goods for hospitals, as in all sound business, are simple—quality, service and a price consistent with both. There should be no other considerations. There is no such thing as "something for nothing," and plausible offers of high discounts, special introductory prices, two articles for the price of one, presents, nonjustifiable donations and similar inducements are but thinly veiled methods of dishonest practice, and unless totally eliminated they are bound to result in disaster for the hospital and unpleasant complications for the superintendent.

Rate of Occupancy in New Jersey General Hospitals

The rate of occupancy in the general hospitals of New Jersey was a little more than 72 per cent for February, a report by Emil Frankel, director of research, department of institutions and agencies, shows. Of the hospitals reporting, 30 per cent had a 60 per cent occupancy, 3 per cent had an occupancy ranging from 60 to 64 per cent, 23 per cent had an occupancy ranging from 65 to 69 per cent, 10 per cent had an occupancy ranging from 70 to 74 per cent, 3 per cent had an occupancy ranging from 75 to 79 per cent and 31 per cent had an occupancy of 80 per cent or over.

Of the total number of patients admitted during the month, 40 per cent were admitted as private and semi-private patients and 60 per cent as ward patients. Of the total patient days of care given during the month, 33 per cent were given to private and semiprivate patients and 67 per cent to ward patients.

The cost per capita per day of all hospitals was \$5.20, the range in per capita cost of general hospitals being from \$2.86 to \$9.63. The amount of receipts from patients covered 68 per cent of the current operating expenses, excluding two city owned hospitals and one county owned hospital that give complete free care.

Concerning the per capita cost per day, 11 per cent of the hospitals reported a per capita cost of \$3.50 a day, 4 per cent, a per capita cost of \$3.50 to \$3.99, 15 per cent, \$4 to \$4.49, 15 per cent, \$4.50 to \$4.99, 5 per cent, \$5 to \$5.49, 17 per cent, \$5.50 to \$6 and 33 per cent, \$6 and over.

Making the Supervisory Field Attractive to Nurses

Why is it that so few nurses are interested in taking special courses to broaden their experiences and to prepare them for the higher positions of supervisors? This was the question asked by Eva Caddy, director of nurses, St. Barnabas Hospital, Newark, N. J., at a round table conference of the New Jersey State Hospital Association in Atlantic City.

"The average salary, when full cost of maintenance, free medical care and hospitalization during illness is added, compares favorably with other fields of work and the full month's vacation is an added inducement, so we cannot feel that inadequate remuneration is the cause. The work is hard, and the long hours and seven-day week are more or less universal," Miss Caddy pointed out.

Does the difficulty lie in the living conditions? Is the worker too completely institutionalized?

"In many schools the supervisors are scattered throughout the student nurses' residence; some groups at least have a separate section reserved for them. In a few schools the supervisors live outside. Facilities for entertaining are provided in a majority of the schools, but in some cases the supervisors are sharing such facilities with students," Miss Caddy pointed out.

One way out of the difficulty, said Miss Caddy, is to make the field so attractive that the young woman who has the ability will seek means of preparing herself for it, rather than having to be urged to follow a course now lacking in appeal.



Supervised Exercise as an Aid to the Mentally Ill

By JOHN EISELE DAVIS, M.A.

Senior Physical Director, U. S. Veterans' Hospital, Perry Point, Md.

A PARAMOUNT problem confronting administrators of mental institutions is the general physical inactivity of the patients submitted to their care and, conversely, an important objective of hospital authorities is to establish a program that will arouse the interest of patients in some form of constructive activity, not necessarily constructive in the economic sense but in the sense of stimulating the healthy interest of the patients and in many cases preventing or arresting deterioration. In many institutions this aim is realized through a comprehensive program of occupational and physiotherapy activities, which includes a wide diversity of supervised formal and informal physical exercise.

Valuable Aid to Treatment

Physical exercise as a valuable aid in the treatment of the mentally ill is being generally accepted, as the result of years of trial and experimentation. It has been fully established that 85 per cent of all psychotics and psychoneurotics of the average age of the veterans of the late war will participate in a comprehensive physical program carefully administered by capable therapists. Any medium that will promote the physical activity of this percentage of the mentally ill is entitled to the serious consideration of those responsible for the administration of the state and federal hospital system. It is of course conceded that this high percentage would not apply to numerous senile cases in state institutions, but most

of the ambulatory patients of this group would engage in suitable graduated calisthenics. The precox group, which represents the largest percentage in the average hospital, the manic depressives and general paralysis cases, whose deterioration is not so pronounced, many traumatic and epileptic cases, will respond readily to a diversified program, administered with careful attention to changing personalities and physical conditions.

Diversified Program Necessary

To provide for the participation of the greatest number in the hospital, a highly diversified and comprehensive program must be devised, which necessitates considerable paraphernalia and many athletic fields and courts. An effective and successful program may, however, be carried out with but little expense. A start may be made in a rudimentary manner by simply grading the patients for suitable calisthenic exercise, which may be given with the aid of the talking machine and records especially made for this purpose. It is of course understood that the physical director will keep in close touch with the ward physician so as to parallel the physical program with the patients' changing personalities and physical conditions. The procedure is thus established as a medical adjunct.

Another natural method of initiating the physical program from the economic standpoint is to enlist the cooperation of patients interested



A group of 360 patients in a calisthenics class, U. S. Veterans' Hospital, Perry Point, Md.

in competitive games and by their aid construct the necessary fields and courts. This provides a healthy and interesting occupational therapy project for the patients. I have constructed in this manner baseball fields, tennis courts, volley ball courts and a handball court with no labor expense. In this connection it is well to remember that many patients have learned a particular game before the onset of their illness and are interested in but one game. There are others who have regressed until their mental and their physical activities are limited to a small sphere and many of these patients can be interested in some particular game but will do nothing else. Others have reached an instinctive behavior level and can be appealed to only through the instinct of play.

Exercise Becomes Part of Life

In many of these patients this interest in exercise will become a part of their life and will enable them to retain control of important bodily functions throughout their natural lives. The economic aspect of this will in all probability be realized only after many years when vital statistics will be available in the hospitals in which a physical program has been instituted. Even the casual observer will be impressed by the avidity with which many aged psychotics participate in special forms of exercise peculiarly adapted to their needs.

For purposes of administration, many institutions, especially state hospitals, have placed phys-

ical exercise under the department of occupational therapy. Other institutions can see no basic relationship between these two and have placed physical exercise in the department of physiotherapy. In the actual application of the physical program it is necessary to differentiate still further by separating formal exercises, including formal active, assistive and resistive exercises, from competitive athletics, the former to be included in the realm of physiotherapy, since this form of exercise, being concerned with postural, structural and functional adjustment, has essentially a physical basis.

On the other hand, competitive athletics have primarily a social objective. The unifying of individual effort with communal aims represents a wide divergence from the types of exercise that are mechanistic and purely formal. This difference is being realized in some quarters and the physical department, separate from both occupational therapy and physiotherapy, has been established. A distinct form of therapy is being found in competitive games, such as baseball, volley ball, tennis, handball, bowling, various indoor competitions and swimming. Most valuable resocializing contacts have been discovered in these games.

The humanitarian character imparted to an institution by athletic games and facilities should not be overlooked in this connection. Many patients will feel more at home in such an atmosphere, where the stern realities and responsibilities of normal life are tempered by an opportunity for natural play and relaxation.



The tug-of-war often provides a natural outlet for the overly active patient.

Why the Hospital Should Lead in Health Promotion*

By JOSEPH R. MORROW, M.D.

Medical Director, Bergen County Hospital, Ridgewood, N. J.

THERE is an old Chinese custom of paying the physician as long as good health is retained and discontinuing the salary when illness comes. And so the prevention rather than the cure of disease is not a new idea in medicine. Intensive campaigns have been conducted by many health organizations in the interests of disease prevention but more and more we are coming to realize that the general hospital with its community interests has an ever increasing part in the program of public health.

I shall not try to outline a specific program for the general hospital to follow in this work, but shall rather call attention to the little everyday things that come under my observation in the administration of a county communicable disease hospital.

Hospitals Assist Health Officers

Boards of health and health officers in their efforts to prevent epidemics are beginning to rely on the general hospitals to put into practice the doctrines they promulgate and hospitals must take practical measures for disease prevention.

The highly communicable nature of the common cold, which may presage a more serious respiratory affliction, has been generally recognized. We now know that these affections have an important epidemiological rôle and should be given the utmost consideration. The sharp line of demarcation between grippe, influenza and pneumonia is fast disappearing. We recognize that these afflictions are caused by the same group of bacteria, that their clinical designation is necessarily arbitrary and that the difference between them is one of degree, type of infections and extent of involvement. It is only a process of continuance from sore throat to laryngitis, to bronchitis, to pneumonia.

It is not a coincidence that in a general hospital where communicable diseases as such, are not admitted, that nurses from time to time develop scarlet fever, and that patients, especially on the surgical service, sometimes develop the disease.

On the other hand, in the hospital specializing in the care of scarlet fever nurses seldom contract the disease from the patient. The reason for this is aseptic nursing. In the general hospital ward where communicable diseases, as such, are not admitted, it has not been considered necessary to enforce sanitary, hygienic and aseptic rules, such as must be rigidly observed in the communicable disease hospital. Hospital personnel properly trained in aseptic technique will not only eliminate the possibility of infection to themselves and to their fellow workers but will also eliminate the possibility of cross infection to patients, especially when the source of infection is not known.

It was through preventive measures that the case incidence of puerperal septic infection was reduced so effectively. If the proper technique and practices were followed outside of operating rooms as well as within them, there would be less cross infection and other unwelcome developments.

It is as much a part of a disease prevention program to prevent scarlet fever, diphtheria or erysipelas developing from a discharging ear, sinus or wound, as it is to be steadily enlarging and developing the out-patient department.

Prevent Spread of Disease

A number of years ago before the Schick and toxin antitoxin era, there occurred in a large and well administered hospital an epidemic of diphtheria among the patients and personnel. A carrier was sought and the entire hospital personnel was cultured, with negative results. Not until the patients in the surgical ward were cultured was it found that an empyema case was profusely discharging Klebs-Löffler laden pus.

With the present tendency on the part of many health departments to reduce the quarantine period of many communicable diseases, it is necessary to exercise even more care in history taking in the admission room, to prevent recent cases of scarlet fever finding their way into the general hospital wards and the operating rooms, with resultant serious effects.

That protection against diphtheria by toxin

*Read at a meeting of the Hospital Association of Pennsylvania, Philadelphia, March, 1929.

antitoxin is not being universally adopted is proved by the yearly toll of lives taken by that disease. The various health organizations and parent-teachers' associations have done commendable work in educating the public on this subject, but indifference continues. While the health organizations' endeavors must of necessity be educational, the general hospital could employ practical methods, in that the many patients admitted each year could be easily Schick tested and the susceptibles immunized with toxin antitoxin, without any discomfort or prolongation of their sojourn in the hospital.

A certificate or a paper of merit is highly prized by the possessor, and if a Schick certificate were given to the patients as a permanent and tangible record of such administration by the attending physician, the bestowal thereof would afford satisfaction to the patients and would offer the hospital the opportunity to manifest its desire for the good health of the patients.

The wards, clinics and out-patient departments could be treated by the house staff at the cost of the material used. Each patient so treated would arouse the interest of his family and friends, and by simple mathematical calculation, we can readily realize how enormous a number of immunizations could be accomplished each year.

Periodic Health Examinations

The opportunities of the hospital to advocate periodic health examinations are manifold, for people who have had a recent experience with hospitals, whether as patients or visitors, are naturally impressed with matters concerning disease, just as one would be reminded of fire insurance after witnessing a burning building. When people are brought face to face with hospitalization, they are in a receptive state of mind for any method that has for its purpose the prevention of the recurrence of illness, and the fact that preventing disease is less expensive than treating disease is the strongest point in the argument.

We shall undoubtedly always have to contend with the question of the increasing cost of operating hospitals. Much of the current criticism is, of course, unwarranted and unjust. However, the fact remains that we have to justify our expenditures, and to some extent we have to employ salesman methods when we are requesting funds or asking for a specific amount in our budgets. Our contentions must be convincing, and many times we must give proof of the economies effected by preventing people from becoming patients. The hospital that is actively engaged in a disease prevention program can show definitely that it is lessening the burden on the community

and on the taxpayers by decreasing the number of dependents, for with disease come poverty and pauperism.

Many who are fortunate in not having been hospital patients are paying taxes and are interested in any method that will assist in keeping down the tax rate. And that is exactly what disease prevention does. There are comparatively few people who cannot meet the small cost of prevention, but many are not financially able to meet the expense of a long sojourn in a hospital.

The exservice man is a concrete example of what education in public health will do. The boys in the American expeditionary forces learned from experience that there were lurking dangers they feared more than bursting shells, and they had genuine regard for the medical service. My experience has been that exservice men invariably are cooperative to the nth degree in public health matters. They not only want protection from disease, but they are anxious that their children receive protection and inoculation for all the preventable diseases for which methods of protection have been devised.

The participation of groups and organizations in health matters and public welfare is ever increasing. The program instituted by the Elks' Lodges of New Jersey, in the form of Cripple Kiddies Committees, directed the attention of other states and of physicians and health workers especially interested in public welfare work, to the woeful neglect of many cripples where preventive measures would have been extremely effective. It also brought that beneficial fraternal association into close contact with the hospitals, to the extent of establishing clinics, equipped and supported by the Order of Elks. Naturally, that interest will broaden beyond that field.

Hospital Facilities for Physicians

At the last meeting of the American College of Surgeons, the president, Dr. Franklin H. Martin, recommended that hospitals place their facilities at the service of physicians for the making of satisfactory periodic health examinations. That the plan could well be tried in the hospitals of county towns, making laboratory facilities available to physicians from rural districts, with benefit to physicians and public alike, seems almost certain.

Let me quote from the *Journal of the Medical Society of New Jersey*, which in turn, quoted from the *King's County Medical Society Bulletin*:

"In order to extend opportunity to every qualified doctor, the hospital could furnish an examining room to which any qualified medical practitioner who is a member in good standing of his

county medical society could bring his patient for examination, so that he might have every facility, such as laboratory tests and x-ray help, with consultants when necessary, to make a comprehensive examination of his patient's condition. There should be no charge for the room and a fair charge should be made for the laboratory and x-ray diagnostic tests. The physician should render his own bill to his patient, collect for laboratory services, pay the hospital and control his own business. No responsibility should be taken by the hospital; no records should be kept other than those in the laboratory and x-ray room, kept by the technician and roentgenologist. The hospital is to be at no other expense, not even the use of a clerk.

"To ensure protection to the practitioner, the hospital should not accord these privileges to any individual not accompanied by his or her doctor, or who does not carry a letter from his or her doctor in which certain services are required."

Compensation for Accident Cases Through Legislation

By C. E. FORD

Chairman, Legislative Committee, Hospital Association of New York State, Albany

"Who is responsible for payment?"

This is a question frequently asked at the time of admission of an accident case but such responsibility is often hard to determine, particularly when the patient is far from home and all participants in the accident are dazed by what has occurred. The result is that patients are admitted, receive treatment, sometimes for an extended period, and depart referring the hospital for payment to the person or corporation alleged to have caused the injury. In few if any states does the hospital enjoy a preferential status in the collection of its accounts. After more or less effective effort to obtain payment has been made, the account is likely to be charged off as uncollectible.

Losses of this kind, while serious enough in large city institutions, are ruinous for the rural hospitals. On Sundays and holidays the country highways and roads are choked with cars and then the injured are taken to the nearest hospitals. To accommodate these accident cases it has sometimes even been necessary to erect tents on the grounds of many rural hospitals.

So serious a burden can hardly be lifted from the hospitals except by legislation. With this in mind the legislative committee of the Hospital Association of New York State decided to try to meet the problem by supporting two bills. One of these amended the Lien Law by giving hospitals a lien for the amount of a reasonable hospital bill on any compensation obtained by injured persons who received care and treatment in the hospitals. Cases covered by the Workmen's Compensation Law were not included in this amendment. It further required that anyone bringing an injured person to a hospital should disclose essential facts, if they were known, such as the name and address of the person causing the injury. Hav-

ing these facts, the hospital must file, within ten days, notice of a claim that would be a lien on compensation obtained by the injured person.

At the hearing conducted by the joint legislative committees of the senate and assembly, representatives of several large corporations, while expressing sympathy with the hospitals in their difficulties, vigorously opposed the bill. Under the provisions of the bill, they said, no settlement of claims with hospital cases could be made until the amount of the hospital bill was ascertained, which ordinarily would only be after the discharge of the patient following treatment.

Patient Benefited by Delay

In the opinion of the legislative committee such delay would frequently benefit the patient in that he would have time and opportunity to obtain disinterested advice as to the amount of compensation to which he is entitled. The strength of the opposition, however, was such that the bill was never reported out of committee. A prominent member of the legislature suggested that the opposition would be less to giving hospitals liens on damages obtained as a result of a judgment of a court, since the settlement of such cases is necessarily delayed by suit at law. While such a limited lien by no means would meet the situation, it would be helpful to hospitals and would mark the acceptance of a principle, details of which could be changed and the extent of coverage increased by later amendment.

When it is impossible to obtain payment for an injured patient from those concerned in the accident, the burden of support should be distributed over the entire community by making the patient a public charge maintained by money raised by taxation. The second bill supported by the association was therefore intended to make provision for the payment of public funds in the care of such cases. The settlement laws of New York are not as rigorous as those of some other states, but still the required residence of one year is sufficient to cause public officials to disclaim responsibility for many emergency cases admitted to hospitals. To meet this situation it was proposed to extend to the cities the authority now conferred on counties to make payments to charitable institutions including hospitals, for persons temporarily or permanently within the community—that is, without reference to the facts of settlement. Under this plan some counties have made appropriations to assist hospitals and other institutions in meeting necessary deficits, an arrangement which seems to have benefited these organizations.

In considering this bill, opposition was expressed by certain organizations and by some cities that were fearful they would be called upon to make large appropriations. The measure as finally passed applied only to Buffalo, which favored the law. Following this action by the second city of the state, favorable action by other localities is looked for.

While the association did not obtain all that it sought, the experience indicates that it may be possible to secure through legislation the following results for the benefit of hospitals: (1) Changes in the law of liens to give hospitals in accident cases a lien on any "insurance or other fund or benefit which may be paid on account of the accident." (2) Such allowance of public funds as shall compensate hospitals for losses necessarily incurred in the treatment of accident cases, resident or nonresident, thereby distributing over the entire community the burden of caring for such cases.

Suggestions for Safeguarding the Operating Room

By R. D. HOBBS

Western Actuarial Bureau, Chicago

FIRE insurance engineers were requested last Fall by various hospital interests to formulate safety rules for the use of combustible and explosive anesthetics. In order to secure uniformity throughout the country, the request was transmitted to the engineering staff of the National Board of Fire Underwriters, New York, and the members of this staff have been working on this problem for the past few months in conjunction with the engineers of the Underwriters' Laboratories, Chicago.

A meeting was held in Chicago in December and another in New York in February, at which representatives of the various hospital interests, as well as the engineers representing the manufacturers, were invited to collaborate with the insurance engineers, with a view to preparing rules that would regulate practical as well as theoretical conditions.

Rules to Be Printed

The following recommendations are the result of these various meetings and represent the consensus of these various interests. They will be published in pamphlet form for general distribution to be used as a guide in dealing with the general problem of safety to life and property in hospital buildings.

Among the anesthetics used to-day, ether, ethylene, propylene and ethyl chlorid are all flammable and liable to form explosive mixtures when mixed with air or oxygen in proper proportion. Nitrous oxid alone or with oxygen is not flammable, but is a supporter of combustion, hence any mixture of nitrous oxid with even a very small amount of ether, such as is sometimes administered, may form a highly explosive mixture.

Ether and ethylene, the most commonly employed anesthetics, differ somewhat as to the lower limit of their respective explosive range, both anesthetics forming explosive mixtures with air or oxygen, under a fairly wide range of conditions. This latter feature is immaterial, however, as the user is only concerned in preventing the formation of the lowest limit of gas and air

or oxygen mixtures that can be ignited, in the location where the anesthetic is employed.

The inherent hazards common to all of these combustible anesthetics have been demonstrated by numerous accidents in hospital operating rooms due to the use of electric cauteries, radio knives, high frequency machines and x-ray fluoroscopic equipment. This danger should be fully recognized. Safe practice dictates the absence of such apparatus in the presence of combustible anesthetics. The electric cautery presents a problem difficult to solve, as its use is often imperative. It seems, however, that this hazard might be overcome by resorting to noncombustible and local anesthetics as far as possible when the use of the electric cautery is demanded.

The cause of some accidents has been puzzling at the time of their occurrence, but subsequent investigation has indicated that they were due to static electricity which is formed in many ways.

So far as safety to life is concerned, the hospital operating room, of all places, should be such as to afford maximum security and protection. For this reason the following recommended safeguards should be rigidly observed.

Recommended Safeguards

1. Cylinders.

a. Any cylinder or container used for storing an anesthetic should be clearly marked with the name of the anesthetic it contains.

b. Cylinders containing gases that may be used in conjunction with the anesthetizing gas should likewise be marked with the name of the gas they contain. This applies in particular to cylinders containing oxygen, nitrogen, carbon dioxid and compressed air.

c. Too much importance should not be placed upon the color of the cylinder; the anesthetist should always look at the label and consider the color as of secondary importance. Cloth covers for cylinders are liable to hide the identity of the gas they contain and therefore should not be used.

d. All cylinders used for the storage of anesthetizing gases or other gases used in connection therewith, should comply with the require-

ments of the Interstate Commerce Commission.

e. Cylinders or cans containing anesthetizing gases or fluids or other gases used for medical purposes, should be stored in dry well ventilated locations. Under no circumstances should they be stored in the operating room, and if an adjoining room is used for this purpose, it should be separated from the operating room by blank walls.¹

f. Cylinders or cans containing anesthetics or other gases should be kept away from radiators and steam pipes. They should be so stored as to prevent contact with fire or sparks from electrical equipment or any other source.

g. Suitable regulators or other gas flow devices should be used in conjunction with any cylinders containing gases used for medical purposes, provided, however, that such regulators or control devices may be dispensed with in the case of low pressure oxygen containers, such as are used in connection with pneumonia and similar cases.

h. No equipment should be used which would permit the intermixing of gases in various cylinders by any error of manipulation. If a cylinder of ethylene is accidentally connected with one containing nitrous oxid, for instance, an explosion would be almost certain.

2. Ventilation.

a. All locations in which combustible anesthetizing agents are employed should be adequately ventilated in order to prevent the lower limit of the explosive range of the anesthetic gas-air mixture being nearly approached. Ventilation by natural means is preferable except as a mechanical system is made necessary in connection with the humidifying system.

b. Where natural ventilation is not feasible, the desired results may be obtained by self-contained electric fans. The motors of such fans should be of a type suitable for use in locations where flammable vapors are present, and fan blades and bearings should be constructed of non-sparking material. Regardless of the type of system employed, fan capacity, arrangement and installation should be such as not to endanger the patient.

3. Electricity for Light and Power.

a. In operating rooms and other locations where combustible anesthetics are used, handled or stored, motors should be of the explosionproof type. This will include motor driving anesthetizing apparatus, fans and similar equipment. Switches controlling such apparatus and lighting circuits should not be permitted within the oper-

ating room unless they are of a type approved for use in locations where flammable vapors are present.

b. Electric lights for illuminating the operating room should preferably be enclosed by vapor-proof globes, as this is the safest arrangement. When ceilings are high, however, the vaporproof globes may be dispensed with, provided lights are protected by mechanical guards, so as to minimize the danger of breakage and the consequent possibility of thereby igniting vapors.

c. Telephones and telephone ringing apparatus should not be placed within the operating room as such apparatus is liable to produce igniting sparks.

4. It should be appreciated that where combustible anesthetics are being employed, the gases exhaled by the patient are within the explosive range or beyond it. Consequently, while the patient is under the influence of the anesthetic, no open flame or other heat or spark emitting device should be used within the operating room. This is not meant to apply to steam or hot water radiators or other low temperature devices employed to keep the patient warm. Where the cautery must be used the attendant hazard may be overcome by resorting to noncombustible and local anesthetics.

5. Static Electricity.

a. The most elusive form of ignition of an anesthetizing gas or vapor is the static spark. To guard against this hazard, insulating material should be avoided, and machines, tables, patients and operators bonded together and to the floor and the latter thoroughly grounded. Even with these precautions the danger of static sparks is not entirely removed, hence it is further recommended that each operating room be provided with a system of humidification, the humidity in no case to be less than 60 per cent. The proper degree of humidity may vary considerably and should be determined by actual tests under working conditions.

b. Door plates at entrances and exits of operating rooms should be thoroughly grounded.

c. Where cylinders or other containers of combustible anesthetics are mounted on a portable truck, precautions should be taken to see that the complete unit is properly grounded.

d. Where a combustible anesthetizing gas is conducted to an operating room or other location through a piping system, such piping system should be thoroughly grounded.

e. Electric charges, which are liable to accumulate on the rubber breathing tube, should be directed away through a spiral wire placed around the tube, connecting with ferrules on the

¹ The provisions of state laws or municipal ordinances governing the storage of compressed gases and flammable liquids must of course be complied with.

ends, or by an internal lining of wire or of metal.

6. Every precaution should be taken to ensure that gas regulators or other devices intended for use with a combustible anesthetic are not used on or with an oxygen cylinder or *vice versa*.

7. Oxygen ignites spontaneously with explosive force when in contact with oils or grease, hence extreme care should be exercised to prevent oxygen cylinders, regulators or pipes or tubes containing oxygen from coming in contact with oil or grease on apparatus or machinery.

8. If heat is necessary to maintain an even flow of gas through the anesthetic apparatus, hot water bags only should be employed.

9. The urgent importance of having readily available a reliable means for auxiliary lighting in case of an emergency is obvious. For this purpose self-contained electric lighting plants of the automatic or semi-automatic type may be used. These, however, should be of makes listed by underwriters' laboratories, with installation fully in accord with the National Electrical Code. Such systems consist of an internal combustion engine, driving electric generators, which in turn charge storage batteries. The hazards of each of these features should be properly guarded against when the installation is made. (See National Board of Fire Underwriters' regulations for the installation of internal combustion engines.) In lieu of the foregoing, emergency lighting demands may in some cases be met by an adequate supply of self-contained electric hand flash lights.

10. In clinics, operating rooms or locations where spare containers of compressed gas or liquid anesthetics are stored, signs should be posted as follows:

No Smoking.

No Open Flames.

No Live Cautery.

11. The recommendations issued by the manufacturers of anesthetizing apparatus should be closely followed.

12. It is highly important that apparatus and equipment in frequent use be maintained in safe operating condition at all times and for this reason it should be thoroughly inspected and tested at frequent intervals.

Developing the Record Department in the Small Hospital

One of the most difficult problems with which the small hospital has to deal is that of the record department and the problem is chiefly a financial one, Minnie Genevieve Morse emphasized in a paper read at the record librarians' round table at the American College of Surgeons' meeting in Boston.

A fifty-bed hospital, however, can have a record department that meets all requirements if it goes about it right. The creation of an active record committee in the medical board and another in the board of trustees will do more than anything else to improve the situation with regard to records.

In the small hospital it may be possible to keep the more recent records in the main office, a few filing cases sufficing for the small number of discharges. Or it may be possible to partition off a corner of the office or the operating pavilion or the out-patient department.

Two ways of starting an efficient department when a trained worker is not available are suggested. One is to borrow a record clerk from another institution long enough to set the machinery in motion and to instruct a member of the personnel in the duties of the department. The other is to send the candidate to a hospital where student record clerks are accepted for a few months' practical experience, on the apprentice plan.

The record clerk should keep regular office hours. The best time is when the doctors are most likely to be in the hospital. It will not take a long list of discharges to occupy her entire time if she writes all the case histories, physical examinations, progress notes and reports of operations from dictation or a dictaphone, uses a fairly complicated indexing system and makes elaborate case summaries, besides compiling medical statistics and answering inquiries. But if all charts are completed before they come to her, the situation will be entirely different.

An elaborate system of record keeping is not necessary to meet the demands of standardization. The simplest way to file charts is to place them in folders, according to a serial discharge number. An alphabetical index, composed of patients' name cards, and some sort of diagnostic card index are absolutely essential. A purely alphabetical list of diseases may be more easily handled by an untrained clerk than a classified list, but a nomenclature in which diseases are listed according to the various systems and regions of the body is useful in compiling medical statistics.

A card index in which all cases are listed under the names of attending doctors is useful, as is also an index of operations. A form of summary sheet or card that covers all the important points of a case is one of the essential details of an efficient record system.

How the Chicago Public Library Cooperates with Hospitals

The therapeutic value of books is being demonstrated in Chicago where, since 1921, the Chicago Public Library has been developing lending libraries in the various hospitals. Alice Wildey in a recent issue of *Hospital Social Service*, states that in one hospital of 275 beds about 900 books were withdrawn monthly while in a 1,000-bed hospital an average of 385 books a week were loaned to patients.

"Hospital boards were dubious, some of them," writes Miss Wildey, "concerning the value of Chicago Public Library's offer of servicing the hospitals with books. Now they are becoming enthusiastic. They have observed the response of patients; they see how books can make a patient forgetful of suffering, and how they can provide a new mental attitude in patients for whom the world has become colorless. They have seen, in other words, the value of books in medical science as well as in the lives of patients made richer because of the library's desire to serve."

Planks in the Hospital's Platform

THE hospital platform should not vary greatly from year to year in the essential planks that go into its construction. The hospital's major object is the efficient care of the sick. Whatever other planks we add to that program should strengthen the entire platform, and we should never lose sight of our main objects and our real reason for existence.

The old notion that hospitals are hotels for the sick has long ago passed away, and now both the progressive physician and the interested administrator look upon the hospital as a scientific institution, where the patient can enter content and confident. The administrator tries in every possible way to make his hospital a place to which the patient will like to come to be cared for and to get well, and from which he can return to his home, reconstructed both in mind and body and capable of carrying on his usual activities.

Hospital's Duty to Speed Recovery

It is the hospital's function to return the patient to his productivity just as soon as it is possible to do so, and upon this platform all programs for hospital operation are built.

It seems to me that the picture changes a little from time to time. It has changed considerably from the old hotel idea within the memory of most of us. The hospitals have had larger and more important and worth while functions added to them. A few years ago the diagnosing and a great deal of the treating of persons who were ill were done in the homes and in the offices of the physicians. Now, to a very large extent, these are done where they should be done, in our institutions.

Our hospitals have been equipped with everything in the way of scientific instruments, material or equipment that the physician needs to make a careful diagnosis and to treat the patient successfully and restore him to health. As time progresses, this is going to change, too. Hospital consciousness is developing to a point where the hospital function will broaden and will give care to the sick, not only during illness, but during that period when the patient's health is on the border line. When he is still an ambulatory patient, treatment will be started, a diagnosis made and every effort put forth to restore him to health without a hospital experience.

And indeed the future program will provide for posthospital care, so that many patients will be

treated by medical men after they are discharged from the hospital and during their period of convalescence, under the direction of the institutions that cared for them while they were definitely ill. Thus we shall link up within the next few years the care of the patient during the prehospital stage with the care of the patient during the time he is acutely ill or injured, and the responsibility for his treatment after he is discharged from the hospital until his return to productivity.

I think when this comprehensive hospital program has been developed along sane and normal lines that the care of the sick will be accomplished to its fullest extent, and that the hospital will assume the responsibility, which now frequently it does not, of seeing that the patient is really cured and restored to health and vigor.

Your hospitals and mine, either individually or in association assembled, can effect those programs, construct those planks in the hospital platform that will promote the development of everything that aids in preventive medicine, in the protection of the community against the invasion of communicable disease, even in the sanitary conduct of the home and of the individual. The hospital program in the future will include all those activities that contribute to the health of the individual and of the community.

Administrator Must Have Vision

These are the things that the sound thinking hospital administrator must visualize as he contributes his share to the work of the hospital world. Somewhere in the Bible there is this reference, "The people who are without vision are lost," and it means just as much to the individual to have vision as it does to a community or to a state or to a nation. In your hospital work and in your institutions, you cannot afford to be complacent. You must keep in step with the development of your profession.

The next thing that seems to me should be given consideration in the planks with which you build your hospital platform is the winning and holding of the confidence of the patient, and before you can do that you have to sell yourselves to that patient. You must make him feel that when he comes into your hospital and meets you there, that he is coming into your professional home, and the courtesy and the hospitality he receives with your first greeting and after his admission and during his stay in your hospital, are

the things that sell the hospital to him and through him to your community.

A hospital in bad repute, a hospital that has a reputation for being cold, unsympathetic, inhospitable, rude, soon loses the confidence of its patients. It contributes in no small degree to their discomfort and delays their recovery. Whatever platform you are building for your hospital, don't forget one thing, that you must earn and keep the confidence and regard of your patients and of your community.

Another plank that hospital people as administrators should give prime consideration to is the maintenance of cordial and friendly relations among the professional staff of their hospitals. There are two great professions that are intimately and constantly interested in the progress of the institution, for it means to them a great deal in a material way and a very large thing in a sentimental way. These two professions are the physicians who are on the staff and the nurses who are taking care of the patients.

Confidence of Staff Important

The administrator who wins and maintains the confidence and good will and sympathy and cooperation of the physicians on the staff and of the nurses as well is never going to lack for patients. The doctors who comprise the staff are going to take their patients to the institution that they feel will give them kind, courteous and efficient service, and they will undertake to get for their patients in cooperation with the hospital, the best of scientific care.

Another plank that you might consider in building your hospital platform is to see to it that every consideration is given to the finances of the patients and that the administration of your hospital is businesslike. Hospitals constitute a business and a very large one. As a group they constitute one of the large industries of the United States. Both in relation to the amount of capital invested and in actual disbursements they rank about seventh of all the large industries in the United States, with a total invested capital in buildings and institutions approximating five billions of dollars and a constant daily expenditure of considerably over a million dollars for operating expenses alone.

In order that the hospital may maintain itself properly, it must give the same careful attention to the business part of its administration that a successful business man would give to his business. It must see that the bills are promptly paid, that the accounts the patients create are taken care of. In doing so every consideration should be given to the financial ability of the patient or

his family to meet the expense incurred in the hospital.

After the rate that the hospital should charge has been determined through the proper agencies, it should be collected. The hospital should not be "hard boiled." The hospital's sentiment, its kindly interest in the patient should be exercised to the fullest extent at the time the patient applies to the hospital for admission, and if the superintendent knows that the patient cannot pay private room rates, he should be asked if he will be satisfied with semiprivate or ward care, and if he cannot pay for either, then just so far as good business will permit and the interest of the institution will allow, those patients who cannot pay should be admitted as charity patients.

A definite charge is being made that the charity bed has disappeared from our hospitals. You will be interested to note that statistical research by the members of the American Hospital Association shows that charity beds have by no means disappeared and that our hospitals—and we take our hospitals as a fair cross section of the hospitals in this country outside of those under control of the government and the different states—are fair examples of this fact.

I say that our hospitals are doing their full share in maintaining and in operating beds for the sick poor, and they will continue to do so, because I can't imagine any hospital as being a hospital of purpose, intent and of any virtue that would not have in its program some arrangement for the care of the indigent sick who may come to it for attention.

Maintain Closer Community Relations

Another plank that might be placed in your hospital platform is a closer community relation between the institution and the community. Due to tradition and often by inclination the hospital administrator and his institution become to some extent isolated, something that is independent of ordinary community activities. The churches constantly maintain their community relations. They encourage every possible means of creating a better understanding among the members of the different denominations. The schools are constantly trying to win the moral and material support of the public. The hospital is not doing all it can do for the general good if it does not change its attitude and try to make friends, both individually and collectively, with the members of the community.

Some time or other, in the way least thought of, the way least seen, this sort of a friendly spirit on the part of your hospitals for your people, will bring a material reward, and every effort that

you make in creating that friendly spirit, by courtesy, kindness, hospitality, is "bread cast upon the waters," and will be returned to your institution in good measure.

One of the best means of coming in contact with the community is through the observance of National Hospital Day. Those of you who have not gone to the trouble to think this plan out will be greatly surprised to know that last year some twelve or fifteen hundred hospitals, particularly the smaller hospitals in different parts of the country, observed this day. They staged quite elaborate programs in many instances for the entertainment of their communities, many held open house and generous hospitality was extended to the public in practically every institution.

Staff Meets Public on Hospital Day

National Hospital Day, coming as it does on the birthday of Florence Nightingale, gives an added sentimental reason for its observance, which is becoming more general as each year goes on, and it affords at least one day in the year when the patients, the staff, the nurses and the employees of the hospital, can come into intimate contact with the people they serve.

President Hoover endorsed the observance of this day this year, and I think the sentiment he expressed in his letter, endorsing its observance, creates a picture of the future of hospitals that perhaps none of us has ever contemplated. In writing to Dr. L. H. Burlingham, president of the American Hospital Association, he said: "The growth of public hospitals in this country is one of the finest manifestations of the quality of opportunity that is the foremost aspiration of the American people. Our citizens will never rest content until the poorest children in our cities, the loneliest mothers on our most isolated farms, have the comfort and the protection of such institutions. I am glad to lend the encouragement of the presidency to the movement symbolized by National Hospital Day."

This year, as it fell on Sunday, the hospitals all through the United States observed Hospital Day in a manner that they have never done before. Ministers devoted the morning or the evening sermon to the subject of National Hospital Day and delivered sermons upon the value of hospitals to the community or upon the life of Florence Nightingale. In the afternoon the hospitals received the public into their professional homes, and gave them an idea of hospital life that will reassure them as to its value and restore and maintain the confidence that they should always have in the institutions.

Another one of the planks that ought to go into a hospital platform is the individual educational effort the administrator must make to keep himself informed of hospital progress. With new ideas constantly challenging, hospitals must progress.

The hospital program is something that cannot stand still, its movement is irresistibly forward, just like the waters in a large river. It flows and gains in power and value and importance as it moves on. Hospital executives are doing that largely in an individual way, through attendance at state and national conventions and by the exchange of ideas. We may not always agree with everything that is said, but whatever lines of agreement or disagreement are developed, something of value is carried away by each individual administrator with each convention he attends.

In our own national convention, we are instituting what we hope will develop into postgraduate schools for the instruction of hospital administrators, by means of round table forums.

We feel that in these open forums discussion will be spontaneous, that new and worth while ideas will be developed and that each one of us will carry home to our hospitals something of value. The Atlantic City convention will probably be the best one that we have ever held. The mornings will be given over to the open discussions of the different sections and the executives of different hospitals from all over the world will contribute their papers and their discussions. The educational exhibit alone will be worth coming across the continent to see. The United States Public Health Service, the United States Army, the Veterans' Bureau, all have large exhibits.

Architects to Have Exhibit

One of the most interesting and most instructive educational exhibits will be that of the American Institute of Architects, who have asked for 300 running feet of exhibit space, in which they propose to show in relief, in pictures, in plans, all of the new hospital constructions in recent years, including power plants, nurses' homes, convalescent homes, out-patient departments and dispensaries.

The commercial exhibit is the largest we have ever staged, 300 booths being occupied by everything that enters into the construction, maintenance and operation of our hospitals. It is in attendance at these conventions that we renew our purpose in life, inform ourselves about the things that exist in our work, develop ideas and reconsecrate ourselves to the service of our fellow men.



RICHARD GEORGE BRODRICK (1871-1929)

VALE

WITH deepest sorrow, THE MODERN HOSPITAL records the death of Dr. R. G. Brodrick on May 2, 1929.

Doctor Brodrick was a man of sterling worth and simple rugged character. His life was useful and he left the world better than he found it. A patriot, he saw service with Dewey at Manila Bay; a sanitarian, he was San Francisco's health officer when Plague stalked abroad; a builder, he planned and erected many of California's finest hospitals; a leader, he gave to the American Hospital Association a year of splendid service as president and many years as a constructive committeeman; a writer, he contributed many lucid, worth while articles to these columns; a friend-maker, he left behind him many who loved him and countless less intimate friends who will always hold his memory in highest respect.

Handicapped by the physical infirmity that caused his retirement from the navy, Doctor Brodrick none-the-less gave constantly and unselfishly of his strength to the upbuilding of hospital medicine. He was just but he was generous; he was great but he was unostentatious; he was forceful but he was not overbearing, and truth abode with him. The hospital field will miss him; the annual meetings will not seem the same without his wise counsels and cheery greetings. His passing leaves a great gap—an emptiness that none can fill. While grieving on our own account, we also mourn with those bound to him by closer and hence stronger ties.

Editorials

Welcome!

THE MODERN HOSPITAL extends a most hearty welcome to each man and woman who has journeyed from a far-off country to attend the first meeting of the International Hospital Congress.

For over two years the hospital field has expectantly awaited your visit. The American Hospital Association fully appreciates the responsibility which it has gladly accepted of acting as your host during your visit to our shores. Its committee on international hospital relations has endeavored to leave nothing undone that would express to you the true feeling of hospitality and of welcome that not only the hospital field but the American people generally have towards you.

From the beginning, THE MODERN HOSPITAL has done all within its power to forward the formation of an International Hospital Congress. It has appreciated that the delegates from afar will not come emptyhanded, that they will not be solely seekers after information as to hospital methods employed in this country, but that they will bring with them the rich background of tradition and experience of European institutions.

The latchstring is out in the 8,000 hospitals of the United States and Canada. The doors of our institutions, be they small or large, urban or rural, in the North or West or South or East, will swing open at your approach. That your visit to America will be pleasant, that the programs of the International Hospital Congress and the American Hospital Association will be profitable, that you may sense the pleasure that will be ours because you have honored us with your presence and that your homeward journey may be safe—these are the fervent wishes of THE MODERN HOSPITAL and its board of editors.

The Possibilities of the Air Hospital

FROM across the ocean there comes an announcement that an aerial hospital is to be employed to treat certain types of diseases in which rarefied air is supposed to be useful. This idea, though novel, even fantastic in its conception at first glance, may have some scientific basis. The belief that certain conditions react favorably to increased or decreased atmospheric pressure is not entirely new.

In one city in this country a huge and expensive compression chamber has been constructed for the treatment of certain rather definite disease states. In another locality, experiments said to be promising are being conducted in the use of rarefied air in its effect on carcinoma in rodents.

To treat patients in an aeroplane or dirigible hospital ward offers to the imagination many interesting possibilities, not the least of which would be the absolute control of the "institution's" personnel. If natural heliotherapy were sought, no dust or smoke obstacles would be encountered and the effect of atmospheric rarefaction on the circulation and chemistry of the blood could be fully studied.

A Blighting Influence

ACCORDING to the eighth annual report of the Council on Medical Education and Hospitals of the American Medical Association, there are 1,813 hospitals in the United States and its territorial possessions that are under government control. While the immediate administrative direction of these institutions may be vested in a resident officer, yet this executive receives his or her orders directly from some elected or appointed official, board or commission.

Federal, state, county and city institutions comprise the above group of hospitals. The total bed capacity of these institutions is 573,106, which represents 64.4 per cent of all the beds in the whole hospital field. There are 369,035 nervous and mental patients being hospitalized throughout the United States, a large percentage of whom are being treated in governmental hospitals. Hence if a uniform rate of bed turnover existed, sixty-four out of every hundred persons who become ill and require hospitalization, go to a federal, state, county or city institution.

Since the controlling board or commission is often seriously affected by a change in the local or general political situation, the tenure of office of the resident supervisory officer of such an institution is apt to be precarious. It is commonly believed also that the efficiency and scientific atmosphere of these institutions are apt to be uncertain because of the nature of the system and the source of the maintenance funds. Do facts bear out these suppositions? Are there influences at work without or within the governmental hospital that place it in a class apart from the hospital that is privately conducted? Does the patient possess as good a chance of quick recovery in the former as in the latter type of hospital? It is the purpose of this series of editorials to

inquire into the existence and effect of the so-called political system in the supervision and conduct of governmental hospitals.

At times during the past century, county and city hospitals have reeked with the stench of political abuses. Managers have pilfered or allowed others to pilfer the supplies intended for the sick. Filth, neglect of patients, absence of scientific vision, immorality and inebriety have been condoned. The favorites of ignorant, petty politicians have been sent back for duty after committing offences unpardonable in a well conducted hospital. Even staff appointments have been allotted by political favor, rather than on the basis of merit. The morale among employees dropped to the lowest ebb and the neglect and abuse of the helpless insane or the general surgical and medical patients were conveniently overlooked if the offenders were a part of the system.

But this picture is not altogether one of the past. Such abuses exist to-day in some degree in too many city, county, state or federal hospitals. The political boss looks with envious eyes on the large number of employees—orderlies, attendants, maids and even nurses—whose votes he desires to control or whose places he wishes to fill. He scoffs at the idea that hospital positions cannot be as well filled by himself as by a trained executive. He wants patronage. He cares little for results other than the attainment of his own selfish ends. Usually without the ability or desire to serve the sick, he fills the hospital with the human refuse that feeds upon the favors of a political system.

But there usually is an educated, even professional man to whom the boss gives orders. He may be a commissioner or director of health or welfare. Unfortunately this executive is usually chosen not for his knowledge or administrative ability but because of political expediency or because no better man could be found. The health and happiness of millions of sick and well may, under our present system in the conduct of governmental health departments as well as hospitals, be placed in the hands of men of no administrative training or personal fitness. Of even more serious import than the lack of preparation for the work is the ruthlessness of such political tools in making the hospital a part of the spoils system. Such men are encouraged in their humanitarian blindness by the fact that usually the body that appropriates money for such institutions does so not solely because it is its duty but because it also expects to get political rewards therefor.

This officer could and has, in some instances under extremely difficult circumstances, with his

back to the wall, protected the clean linen and bodies of his patients from the smirch left by the touch of the grimy and greedy hand of politics. Politics and health will not mix. When such an attempt is made a nauseous and harmful mixture results, deadly to hospital morale and to the patients' chances of speedy recovery.

Miss Hamlin Resigns

ELSEWHERE in this issue there appears a notice that the American Hospital Association will assume the administration of the Hospital Library and Service Bureau, which for nine years has been conducted under the auspices of the American Conference on Hospital service. Donelda R. Hamlin, the director of the library since its organization, has tendered her resignation to take effect on June 25, 1929.

Miss Hamlin as the director of the Hospital Library and Service Bureau has shown unusual talents for organization and administration and has had a broad understanding of the real purposes of the library. It is these qualities of mind and heart that have made the institution successful. She has labored indefatigably and unselfishly in the development of the library and has imparted the same qualities of real service to her subordinates in the work.

Miss Hamlin has made hosts of friends throughout the hospital world by her tact, sympathy and understanding of the needs of the hospital public and these friends regret her resignation from the important position she has so splendidly filled.

F. B.

The Hospital's Responsibility Toward Its Nurse Graduates

THIS is the season of flowers, feminine spring finery and nurses' graduations. The commencement orator is enjoying his heyday at the expense of defenseless novitiates in the profession of nursing. Yet there is much that is stimulating and symbolic in the commencement exercises of schools for nurses. The observer, no matter how blasé, cannot avoid a tightening of the throat when he views a marching line of blue and white—when the graduate for the first time clad in the long desired starched white and proudly wearing the cap with the significant frill, appears.

The three years of her training are in the past, the records she has made are closed, the contribution of the hospital to her future personal welfare and community usefulness is complete. She is

henceforth not so much on trial as is her hospital, its superintendent of nurses, its board of trustees. If high educational, ethical and professional ideals have become a part of her very being, the future of nursing, insofar as she is concerned, is safe. If she has been allowed to pass her probationary days ill equipped in personality, intellect or vision to meet properly the high ideals of her profession, the fault lies elsewhere than at her door.

The molding of the pliable character of the young woman who enters our hospitals in search of learning is largely in the hands of the hospital and its nursing and medical staffs. As she emerges, clad in the garb of the graduate, in a large measure she but reflects the character and re-echoes the beliefs of those with whom she has been associated and to whom she has looked with a respect sometimes akin to awe. If a graduate in nursing falters in meeting the public's expectations, should not her school and its superintendent share the blame? When the public encounters in the graduate nurse gentleness, dignity and tact, coupled with scientific skill, it will loosen its purse strings to support her education.

The Cleveland Disaster

THE Cleveland Clinic tragedy has immeasurably shocked the hospital world and the nation, and there is pity everywhere for those who mourn the unfortunate victims. Sympathy is extended, too, on every hand to Dr. George W. Crile, the founder of the clinic and a surgeon of international reputation and to his able associates who met the emergency with the same qualities of heroism that were exhibited by some of them during the World War.

Tribute should be paid also to the hospitals of Cleveland, notably to Mt. Sinai and Lakeside Hospitals, the two nearest the scene of the catastrophe, which handled the emergency in a marvelously efficient manner.

The story of the disaster has been made known to all through the public press and the details will not be related here. Spontaneous combustion (decomposition) in an overheated basement room used in part for the storage of x-ray films caused, it is said, the fire and explosions that damaged the clinic building and took the lives of between one and two hundred persons. There is an added element of regret in the possibility that had greater precaution been taken in the storing of the highly inflammable films the calamity might perhaps have been, at least in some measure, averted.

Since the publication of an exhaustive article in our issue of December, 1924, THE MODERN HOSPITAL has repeatedly emphasized the dangers

inherent in the storing of x-ray films and has urged that every precaution be taken by hospitals to prevent a disaster such as has now occurred. In view of the fact that it now becomes the imperative duty of the public authorities, the hospital field and the whole community to put forth every effort to safeguard hospital patients and personnel against similar tragedies that might arise, we are including in this issue, as a service to our readers, suggestions for meeting the problem in a practical manner.

While the attention of the hospital world is now centered on the sudden and merciless results of x-ray film explosions, there are other potential sources of fire in hospitals that demand careful attention and preventive measures. The danger of fire from anesthetic gas explosions was dealt with in our February issue and on page 86 of this issue suggestions for safeguarding the operating room are presented.

Resolution by the National Board of Fire Underwriters

It is with much satisfaction that we are able to present herewith the resolution adopted by the National Board of Fire Underwriters at its annual meeting on May 23, a resolution which we heartily endorse.

RESOLVED that the National Board of Fire Underwriters at its annual meeting assembled in New York this May 23rd, 1929, does hereby extend sincere sympathy to all those who have suffered or who may have lost relatives and friends by the appalling disaster at the Cleveland Clinic in the City of Cleveland, Ohio, and through the medium of a special committee, to be appointed by the president and to cooperate with the committee on fire prevention and engineering standards of the National Board of Fire Underwriters, with Underwriters Laboratories and with Inspection Bureaus in the various states, does hereby freely offer to all hospitals throughout the country its services and its engineering force to aid trustees and other hospital officials in developing plans for the saving of life and property from fire, explosion and other such hazards; particularly are those services extended to the American Hospital Association, the Catholic Hospital Association of the United States and Canada, the American Protestant Hospital Association, the American Medical Association and the American College of Surgeons, each of which organizations is cordially invited to appoint a committee from the membership of which a joint representative committee may be selected for general cooperation with the National Board of Fire Underwriters in the humane and highly important work referred to.

Must We Have Another X-Ray Film Tragedy?

FOLLOWING the Cleveland disaster of May 15, the current topic of discussion in all hospitals now is the proper storage of x-ray films. The findings of the investigation of the catastrophe now under way will be eagerly awaited and will doubtless lead to careful reconsideration of the whole problem of storing explosive films capable of liberating deadly fumes.

In the meantime inquiries are being made on every hand regarding extra-precautionary measures that will ensure hospitals a maximum of safety in this respect, and **THE MODERN HOSPITAL** has been asked to reprint material relating to protective measures that has appeared in previous issues of the magazine. Among the most pertinent suggestions presented in the numerous articles published in the magazine during recent years are those of R. D. Hobbs, Western Actuarial Bureau, Chicago, who gives an intelligent discussion of the subject in an article entitled "Minimizing the Fire Hazards of X-Ray Films,"¹ excerpts from which appear on the pages that follow.

THE increasing use of x-ray films in hospitals has introduced a fire hazard that is more or less recognized, although in many instances little serious thought has been given to the necessity for safeguarding the handling and storage of

films so as to prevent a fire endangering life and property.

The x-ray films commonly in use are made of a base termed "the skin," which is a nitrocelluloid made of cotton treated with nitric and sulphuric acid. These make a plastic mass, highly inflam-

¹THE MODERN HOSPITAL, November, 1928.



General view of the scene of catastrophe at Cleveland.

Pacific & Atlantic Photos, Inc.

mable and similar to gun cotton. This is spread upon polished surfaces and cut to the desired size, forming a film which when coated with a nitrate of silver solution is ready for the picture. Tests on a one-foot length of film have indicated that if ignited it will be entirely consumed in twelve seconds. A similar quantity of ordinary pulp paper would be consumed in thirty-five seconds, while rag paper would be consumed in forty-five seconds. Furthermore, in burning, the films give off a highly flammable and explosive gas.

The exposed film, or negative as it is called by the trade, constitutes a hazard depending upon the quantity stored and the manner of its storing. It has the same susceptibility to quick ignition and spread that other nitrocelluloid products have and it will decompose with evolution of dangerous gases at a relatively low temperature. To preserve the negatives it is the usual practice to keep them in envelopes of heavy Manila paper or to place them in the original carton or shipping box. The insulation thus provided considerably retards the rate of combustion. If heated sufficiently to start decomposition the usual dense fumes are given off, but the insulation provided by the heavier paper or cardboard prevents the building

up of a high enough temperature to ignite these gases. It is obvious therefore that safe storage can be obtained for films of this character if relatively small quantities are kept in properly vented cabinets.

That there is a hazard in the storage and use of x-ray films seems to be fairly well recognized by hospital authorities because recent inspection of many hospitals shows that some effort has been made in each instance to provide a means of taking care of the films. A recent inspection in a large city revealed two rather extreme instances of the efforts made to guard against this danger. In one case the x-ray department is on the top floor of a comparatively new fireproof unit, which is equipped with automatic sprinklers. The laboratory being on the top story, it was found convenient to place the film storage vault on the roof of the building. This was constructed with a concrete floor and roof and walls of 12-inch brick, a wire glass skylight, a ventilator, vaporproof electric light globes, fire extinguishers and a self-closing tin-clad door. The films are filed in Manila envelopes on metal racks.

Let us consider what was found in another hospital. In a large office opening directly on to a



Scene while rescue work was in progress.

Pacific & Atlantic Photos, Inc.

main corridor of the main building, with wards on either side, approximately 300 pounds of films forming the current or running file are filed in Manila envelopes on a wooden rack. This rack is within a few feet of chairs arranged for patients and others, the room apparently being used as a waiting room. Films were littered along the table in this room, awaiting filing.

Across the corridor and in a small room with an ordinary wooden door, new films are kept in the original packages. This storage room is an interior closet not easy of access and is lighted by a drop light from which four or five additional lines are taken. The fixture is grossly overloaded and the wiring is in bad condition. The main storage room for the films, occupying 450 cubic feet, is on the main corridor, near the elevator, and is separated by a heavy wooden door, not self-closing but normally kept closed. No ventilation is provided although there is a window which is kept closed. The ceiling and floor of the vault are concrete and the walls are brick. Approximately 3,000 pounds of films are stored in this vault, the negatives being filed in cardboard boxes, each box containing from five to twenty negatives. The boxes are arranged on wooden racks. A radiator on the floor is in close proximity to the racks which hold the boxes containing negatives.

Here we have two extremes, one where every possible precaution has been taken to safeguard life and property and the other representing a

real hazard to both life and hospital property.

There are three problems in connection with the use of x-ray films in hospitals—the main file, the new films and the current file. As a general rule the current file is kept in an office, the new films in either the dark room or the x-ray room and the main file in a separate room. Each of these three situations presents a different hazard.

Unexposed films should be stored in metal boxes or cans (constructed of lead or lead-lined) on shelves two feet above the floor, or in approved double wall cabinets, vented to the outside air. The amount of unexposed films in standard containers kept outside of standard vaults should not exceed fifty pounds.

In some of our larger cities it has been found that the current or running file consists of from 500 to 3,500 films. In some instances the films are filed in ordinary filing cases in the main office, while in other instances they are kept in a fireproof vault with the main storage. When the current file is kept outside a fireproof vault the number of films should be kept to a minimum and transferred to the main storage vault as rapidly as conditions will permit.

There is another and easier way to control this situation, although an inspection of hospitals indicates that it has not met with popular

favor. There is a so-called noninflammable film, made by treating cotton with acetic anhydride and acetic acid, and producing the same results physically but with the danger removed. The coating is

General Rules and Cautions

1. A metal can having a self-closing spring hinged cover and approved by the Underwriters' Laboratories should be provided for all waste negatives and film scrap, and at no time should these be permitted to accumulate and lie around on tables, benches or floor.

2. Stocks of unexposed films should be kept at a minimum. Only a limited supply should be kept on hand at any one time.

3. In rooms where films are filed or handled there should be no flames or any other than standard electrical fixtures. The use of portable lights on extension cords should be prohibited. All open lamp bulbs should be protected from breakage by suitable guards. An approved hand fire extinguisher should be in each room where films are handled. Doors of dark rooms and of other rooms should be arranged so as to make egress easy.

4. Film negatives should be filed as soon as possible in heavy Manila envelopes, either singly or by case. These should be conveniently arranged so that from time to time useless negatives may be weeded out.

5. Film illuminators should be so designed that the diffusing glass is not hot to the touch and there should be no unnecessary display of film negatives in lighted illuminators. Negatives set up for viewing should be confined to those actually being inspected.

6. Smoking should be prohibited in rooms where films are stored, in developing rooms and in similar workrooms. "No Smoking" signs should be posted in prominent places.

7. No films should be stored within two feet of steam pipes, radiators, chimneys or other sources of heat.

similar to the other and it is used in the same way. The price of acetic anhydrid makes the film a little more expensive. The noninflammable film is not unburnable as the name implies, but it is as safe as paper and rags, if not more so, for although its point of ignition may be a little lower than the others its rate of burning is less and therefore the spread of the flame is slower without the production of dangerous gases. It is unnecessary to require any storage conditions for celluloid acetate films.

The chief objection to the use of the slow burning film is that it has a tendency to roll and is not so easily filed. Thus property and lives may be endangered to facilitate handling and filing.

In the following rules and standards reference will be made to films in pounds, and the accom-

<i>No. of Negatives</i>	<i>Size</i>	<i>Approximate Weight</i>
1000	14x17 in.	118 lbs.
1000	12x14 in.	100 lbs.
1000	10x12 in.	60 lbs.
1000	8x10 in.	40 lbs.

panying table may be used as a guide in computing the weight of films.

When over 250 pounds of films are stored they should be kept in a standard fireproof film vault constructed as follows:

1. A film vault shall not exceed 750 cubic feet in actual storage capacity, including aisles. The floor and walls of every such vault shall be of brick at least eight inches thick or of reinforced concrete at least six inches thick. The roof shall be of reinforced concrete at least six inches thick. Walls, ceilings and floors of existing buildings that conform to these requirements may serve as wall, roof or floor of such a vault, provided the other protective barrier or barriers composing the vault are rigidly tied into them and the interior vault space is limited in each case to 750 cubic feet.

2. A fire door shall be provided on each face of the wall to door openings leading into such vaults. Such doors shall be of an approved type, that is, bearing the label of the Underwriters' Laboratories. The interior door shall be made to close automatically. The outer door shall be of the swinging type and shall be made to close into a jamb so as to prevent the passage of flame around the edges. It shall be self-closing and so arranged as to close automatically in case of fire originating inside or outside the vault at such times as it may be temporarily fastened open.

3. No skylights shall be permitted.

4. Slatted shelves shall be divided vertically at intervals not exceeding 10 feet. Backs and

divisions shall be preferably of incombustible material, or of $\frac{7}{8}$ -inch tongued and grooved boards, or their equivalent in resistance to heat and gases. Slats shall be not over 4 inches wide and spaced at least one inch apart. Aisle space shall be at least 3 feet wide. Height of racks shall be not over 8 feet and in no case shall stock be stored higher than 2 feet below sprinkler deflectors.

5. Each storage room shall be equipped with automatic sprinklers, arranged according to the sprinkler regulations insofar as applicable. A sprinkler head shall be installed in the center of the aisle opposite each section. The area to be covered by each sprinkler head shall not exceed 64 square feet of floor area.

A room so located on the roof as not to endanger other parts of the building requires automatic sprinklers only when salvage of the contents is desired or when there is probability of panic from the fumes.

6. An adequate vent to the outer air shall be provided. The area of the vent shall be equal to a clear opening of at least one-half square inch per cubic foot of room. Such vent may be provided by installing approved heat-releasing devices on the windows, preferably on the upper sash, arranged to open windows automatically.

7. Heating should preferably be by hot water. When steam heating is used, only low pressure steam shall be permitted. Radiators or coils shall be on the ceiling or shall be adequately screened, and pipe lines shall be protected and screened.

When it is not possible or practicable to have a storage vault or when it is necessary to have a large current or running file, such films may be safely stored in an approved fire resistive cabinet constructed as follows:

No cabinet shall exceed thirty cubic feet in capacity. Cabinets shall be of approved insulated construction.

Cabinets having a capacity in excess of 200 pounds of films shall be divided into at least two distinct compartments; each compartment provided with an independent door and vent. The separating partitions should be practically airtight and should be of substantial construction, equivalent to the sides.

Cabinets holding over 100 pounds of films shall be equipped with at least one automatic sprinkler in each compartment unless each compartment holds less than thirty pounds of films, and the construction is such that fire will not extend from one compartment to another.

Each compartment shall be provided with a vent to the outside air. The vent shall have a cross sectional area of at least one square inch per cubic foot of capacity of the cabinet.

A. H. A. Takes Action

THE following joint letter was sent out from the headquarters of the American Hospital Association on May 17, to every hospital in the United States and Canada, accompanied by the list of Underwriters Inspection Bureaus that appears on the following pages.

TO HOSPITAL TRUSTEES AND SUPERINTENDENTS:

The Nation is shocked by reason of the terrible hospital catastrophe that occurred in Cleveland, Ohio, on Wednesday, May 15th, 1929.

The primary cause of the accident which at present is attributed to a fire in the X-ray film storage room, is as yet not definitely decided, but full investigation is in process and the true facts will be ascertained as soon as possible.

We fully realize the danger of combustion in film storage rooms where combustible films are used, and strongly urge the utmost caution. At the same time we feel it would be unwise for hospitals, in the excitement due to this catastrophe, to hurriedly make structural changes without securing competent advice from those who have made a study of the hazards.

To this end we are enclosing a list of the various Underwriters Inspection Bureaus, who are fully informed as to the standards of the National Board of Fire Underwriters, and suggest that you communicate with the Bureau nearest your hospital before making changes.

In the meantime, we would urge you where possible, to remove all excess films to a safe distance from the hospital, when such films are not now stored in vaults properly constructed and fully ventilated in accordance with the recommendations of the respective Inspection Bureau and the National Board of Fire Underwriters.

LOUIS H. BURLINGHAM, M. D.,
President, American Hospital Assn.

BERT W. CALDWELL, M. D.,
Exec. Sec., American Hospital Assn.

ARNOLD H. KEGEL, M. D.,
Commissioner of Health, City of Chicago.

OLIN WEST, M. D.,
Sec. & Gen. Mgr., American Medical Assn.

ASA S. BACON,
Supt., Presbyterian Hospital, Chicago.

S. S. GOLDWATER, M. D.,
Hospital Consultant, New York.

E. S. GILMORE,
Supt., Wesley Memorial Hospital, Chicago.

N. W. FAXON, M. D.,
Supt., Strong Memorial Hosp., Rochester,
N. Y.

C. G. PARNALL, M. D.,
Med. Dir., Rochester Gen. Hosp.,
Rochester, N. Y.

ALFRED MEYER,
Pres., Board of Trustees, Michael Reese
Hospital, Chicago.

REV. ALPHONSE SCHWITALLA,
Pres., American Catholic Hospital Assn.,
St. Louis, Mo.

REV. J. H. BAUERNFEIND,
Pres., American Protestant Hospital Assn.,
Chicago, Ill.

WALTER H. CONLEY, M. D.,
General Med. Supt., Dept. of Hospitals,
New York City.

MISS MARGARET ROGERS,
Supt., St. Lukes Hospital, St. Paul, Minn.

RICHARD P. BORDEN,
Pres. of the Board of Trustees, Union Hos-
pital, Fall River, Mass.

GEO. F. STEPHENS, M. D.,
Supt., Winnipeg General Hospital, Win-
nipeg, Manitoba.

LEWIS A. SEXTON, M. D.,
Supt., Hartford Hospital, Hartford, Conn.

Inspection Bureaus Offer Counsel on Film Storage

THROUGH the courtesy of those who have been assisting THE MODERN HOSPITAL in its educational program for fire prevention in hospitals, we are able to present herewith a complete list of Inspection Bureaus cooperating with the National Board of Fire Underwriters. Hospital executives in any doubt as to the adequacy of their provisions for safeguarding life and property in their hospitals may consult the experts attached to the inspection bureaus listed below.

National Board of Fire Underwriters,
85 John Street, New York.
W. E. Mallalieu, Gen. Mgr.

ALABAMA

Alabama Inspection & Rating Bureau,
Offices: Montgomery and Birmingham.

ARIZONA

Arizona Equitable Rating Bureau,
Main Office: Heard Building,
Phoenix, Arizona.
M. R. Colwell, Chief Surveyor.

ARKANSAS

Arkansas Fire Prevention Bureau,
Main Office: Hall Building,
Little Rock, Arkansas.
T. F. Baker, Mgr.

CALIFORNIA

Board of Fire Underwriters of the Pacific,
Main Office: Merchants Exchange Bldg.,
San Francisco, California.
H. F. Badger, Jr., Secy.
Branch Office: Los Angeles, California.

COLORADO

Mountain States Inspection Bureau,
Main Office: Gas & Electric Building,
Denver, Colorado.
L. H. Simonton, Mgr.
Branch Office: Pueblo, Colorado.

CONNECTICUT

New England Insurance Exchange,
Main Office: 40 Broad Street,
Boston, Massachusetts.
Branch Office: Hartford, Connecticut.

DISTRICT OF COLUMBIA

Underwriters Association of the District of Columbia,
Main Office: Woodward Building,
Washington, D. C.
E. R. Hardy, Mgr.

FLORIDA

Southeastern Underwriters Association,
Main Office: Atlanta, Georgia.
W. F. Dunbar, Mgr.
Branch Offices:
Florida Inspection & Rating Bureau,
Jacksonville and Tampa, Florida.

GEORGIA

Southeastern Underwriters Association,
Main Office: Atlanta, Georgia.
W. F. Dunbar, Mgr.

Branch Offices:

Georgia Inspection & Rating Bureau,
Atlanta and Savannah, Georgia.

IDAHO

Idaho Surveying & Rating Bureau,
Main Office: Boise, Idaho.
J. H. Branscomb, Mgr.

ILLINOIS

(Except Cook County)
Illinois Inspection Bureau,
Main Office: 108 E. Ohio Street,
Chicago, Illinois.
F. H. Jones, Mgr.

Branch Offices:

Springfield, Peoria, Rockford, Joliet, Rock Island,
Quincy, Mt. Vernon, Champaign and East St.
Louis, Illinois.

(Cook County Only)

Chicago Board of Underwriters,
Main Office: Insurance Exchange Building,
Chicago, Illinois.
E. Palmer, Mgr.

INDIANA

Indiana Inspection Bureau,
Main Office: 320 North Meridian Street,
Indianapolis, Indiana.
E. M. Sellers, Mgr.

Branch Offices:

Evansville, Fort Wayne, South Bend and Terre
Haute, Indiana.

IOWA

Iowa Insurance Service Bureau,
Main Office: Insurance Exchange Building,
Des Moines, Iowa.
K. L. Walling, Mgr.

Branch Offices:

Cedar Rapids and Sioux City, Iowa.

KENTUCKY

Kentucky Actuarial Bureau,
Main Office: Stark Building,
Louisville, Kentucky.
G. H. Parker, Mgr.

Branch Offices:

Ashland, Covington, Lexington, Owensboro, Paducah and Pineville, Kentucky.

KANSAS

Kansas Inspection Bureau,
Main Office: 701 Jackson Street,
Topeka, Kansas.
W. C. Hodges, Mgr.

Branch Offices:

Wichita and Kansas City, Kansas.

LOUISIANA

Louisiana Rating & Fire Prevention Bureau,
Main Office: Queen & Crescent Building,
New Orleans, Louisiana.
R. P. Strong, Secy.-Treas.
Branch Office: Shreveport, Louisiana.

MAINE

New England Insurance Exchange,
Main Office: 18 Oliver Street,
Boston, Massachusetts.
Ralph Sweetland, Mgr.

MARYLAND

(Except City of Baltimore)
Underwriters Assn. of the Middle Department,
Main Office: 414 Walnut Street,
Philadelphia, Pa.
Louis Wielderhold, Jr., Secy.
(City of Baltimore)
The Assn. of Fire Underwriters of Baltimore City,
Main Office: 8-10 South Street,
Baltimore, Maryland.
John H. Kenny, Secy.-Mgr.

MASSACHUSETTS

(Except City of Boston)
New England Insurance Exchange,
Main Office: 40 Broad Street,
Boston, Massachusetts.
Ralph Sweetland, Mgr.
(City of Boston)
Boston Board of Fire Underwriters,
Main Office: 55 Kilby Street,
Boston, Massachusetts.
Wm. H. Winkley, Mgr.

MICHIGAN

Michigan Inspection Bureau,
Main Office: Cadillac Square Building,
Detroit, Michigan.
O. M. Henn, Mgr.
Branch Offices:
Jackson, Saginaw, Grand Rapids and Negaunee,
Michigan.

MINNESOTA

General Inspection Bureau,
Main Office: Plymouth Building,
Minneapolis, Minnesota.
Fisher & Lund, Mgrs.
Branch Offices:
Duluth, St. Paul and Winona, Minnesota.

MISSISSIPPI

Mississippi State Rating Bureau,
Main Office: LaMar Life Building,
Jackson, Mississippi.
Lloyd T. Wheeler, Mgr.

MISSOURI

Missouri Inspection Bureau,
Main Office: Pierce Building,
St. Louis, Missouri.
Jas. A. Waterworth and Paul W. Terry, Mgrs.
Branch Offices:
Kansas City, St. Joseph, Joplin and Hannibal,
Missouri.

MONTANA

Board of Fire Underwriters of the Pacific,
Main Office: Merchants Exchange Building,
San Francisco, California.
H. F. Badger, Jr., Secy.
Branch Office: Butte, Montana.

NEBRASKA

Nebraska Inspection Bureau,
Main Office: Standard Oil Building,
Omaha, Nebraska.
Frank Stanbery, Mgr.

NEVADA

Board of Fire Underwriters of the Pacific,

Main Office: Merchants Exchange Building,
San Francisco, California.
H. F. Badger, Jr., Secy.

NEW HAMPSHIRE

New Hampshire Board of Underwriters,
Main Office: Concord, New Hampshire.
L. Clarner, Jr., Secy.

NEW JERSEY

The Schedule Rating Office of New Jersey,
Main Office: 31 Clinton Street,
Newark, New Jersey.
Leon A. Watson, Expert.

NEW YORK

(Entire State, except Territory of New York,
Suburban, and Buffalo Districts)
New York Fire Insurance Rating Organization,
70 Gurney Building,
Syracuse, New York.
Lawrence Daw, Secretary.
Boroughs of Manhattan, Bronx (West of Bronx River)
and Brooklyn, Long Island City, and American Docks
and Stores in Richmond Borough.
New York Fire Insurance Rating Organization,
85 John Street,
New York City, New York.
Harold S. Hess, Mgr.

Long Island and Staten (except as noted above)
Borough of Bronx, east of the Bronx River.
Westchester, Putnam and Rockland Counties.
New York Fire Insurance Rating Organization,
85 John Street,
New York City, New York.

W. J. Ward, Mgr.
Entire City of Buffalo, Township of Wheatfield,
Town of Tonawanda, North Tonawanda and
Kenmore.
New York Fire Insurance Rating Organization,
Marine National Bank Building,
Buffalo, New York.
E. H. Sigison, Mgr.

NORTH CAROLINA

Southeastern Underwriters Association,
Main Office: Atlanta, Georgia.
W. F. Dunbar, Mgr.

Branch Offices:

North Carolina Inspection & Rating Bureau,
Raleigh, North Carolina.

NORTH DAKOTA

General Inspection Bureau,
Main Office: Plymouth Building,
Minneapolis, Minnesota.
Fisher & Lund, Mgrs.
Branch Office: Fargo, North Dakota.

OHIO

Ohio Inspection Bureau,
Main Office: Hartman Building,
Columbus, Ohio.
T. B. Sellers, Mgr.
Branch Offices:
Akron, Cincinnati, Cleveland, Dayton, Lima, Ports-
mouth, Springfield, Steubenville, Toledo and
Youngstown, Ohio.

OKLAHOMA

Oklahoma Inspection Bureau,
Main Office: Oklahoma City, Oklahoma.
C. T. Ingalls, Mgr.
Branch Office: Tulsa, Oklahoma.

OREGON

Oregon Insurance Rating Bureau,
Main Office: Lumbermen's Building,
Portland, Oregon.
Jas. N. McCune, Mgr.

PENNSYLVANIA

(Except Allegheny, Philadelphia, Bucks, Chester, Delaware and Montgomery Counties)

Underwriters Assn. of the Middle Dept.,
Main Office: 414 Walnut Street,
Philadelphia, Pennsylvania.

Louis Wiederhold, Jr., Secy.

(Bucks, Chester, Montgomery and Delaware Counties)

Philadelphia Suburban Fire Underwriters Assn.,
Main Office: 331 Walnut Street,
Philadelphia, Pennsylvania.

A. P. Stradling, Secy.

(Allegheny County)

Board of Fire Underwriters of Allegheny County,

Main Office: Commonwealth Building,
Pittsburgh, Pennsylvania.

R. J. Trimble, Secy.

(City of Philadelphia and County)

Philadelphia Fire Underwriters Assn.,
Main Office: 131-141 South Fourth Street,
Philadelphia, Pennsylvania.

J. Sanderson Trump, Secy.

RHODE ISLAND

(Except Providence)

New England Insurance Exchange,
Main Office: 40 Broad Street,
Boston, Massachusetts.

Ralph Sweetland, Secy.

(City of Providence)

Insurance Assn. of Providence,
42 Weybosset Street,
Providence, Rhode Island.

Edward Devine, Secy.

SOUTH CAROLINA

Southeastern Underwriters Association,
Main Office: Atlanta, Georgia.

W. F. Dunbar, Mgr.

Branch Office:

South Carolina Inspection & Rating Bureau,
Columbia, South Carolina.

SOUTH DAKOTA

General Inspection Bureau,
Main Office: Plymouth Building,
Minneapolis, Minnesota.

Fisher & Lund, Mgrs.

Branch Office: Sioux Falls, South Dakota.

TENNESSEE

Tennessee Inspection Bureau,
Stahlman Building,
Nashville, Tennessee.

F. B. Quackenboss, Mgr.

Branch Offices:

Knoxville, Chattanooga and Memphis, Tennessee.

TEXAS

Texas State Fire Insurance Commission,
Main Office: Austin, Texas.
John M. Scott, Chairman.

UTAH

Board of Fire Underwriters of the Pacific,
Main Office: Merchants Exchange Building,
San Francisco, California.

H. F. Badger, Jr., Secy.

Branch Office: Salt Lake City, Utah.

VERMONT

New England Insurance Exchange,
Main Office: 40 Broad Street,
Boston, Massachusetts.
Ralph Sweetland, Mgr.

VIRGINIA

Southeastern Underwriters Association,
Main Office: Atlanta, Georgia.

W. F. Dunbar, Mgr.

Branch Offices:

Virginia Inspection and Rating Bureau,
Richmond, Virginia.

(Entire City of Norfolk)

Underwriters Inspection Bureau,
Norfolk, Virginia.

WASHINGTON

Washington Surveying and Rating Bureau,
Main Office: Alaska Building,
Seattle, Washington.

Branch Offices:

Spokane and Tacoma, Washington.

WEST VIRGINIA

West Virginia Inspection Bureau,
Main Office: Hartman Building,
Columbus, Ohio.

T. B. Sellers, Mgr.

Branch Offices:

Charleston and Wheeling, West Virginia.

WISCONSIN

Wisconsin Inspection Bureau,
Main Office: Underwriters Building,
Milwaukee, Wisconsin.

George E. Nichols, Mgr.

Branch Offices:

Eau Claire, Madison, Oshkosh, Superior and Wausau, Wisconsin.

WYOMING

Mountain States Inspection Bureau,
Main Office: Gas and Electric Building,
Denver, Colorado.

L. A. Simonton, Mgr.

Branch Office: Cheyenne, Wyoming.

CANADA

British Columbia Fire Underwriters Assn.,
Main Office: Vancouver, British Columbia.
Branch Office: Victoria, Vancouver.

Western Canada Fire Underwriters Assn.,
Main Office: Winnipeg, Manitoba.

A. H. Stead, Secy.

Canadian Fire Underwriters Assn.

Main Office: Toronto, Ontario.

A. W. Goddard, Secy.

Canadian Fire Underwriters Assn.

Main Office: Montreal, Quebec.

L. Howgate, Secy.

Nova Scotia Board of Fire Underwriters,

Main Office: Halifax, Nova Scotia.

Edward J. Fahie, Secy.

New Brunswick Board of Fire Underwriters,

Main Office: St. John, New Brunswick.

Peter Clinch, Secy.

Prince Edward Island Board of Fire Underwriters,

Main Office: Charlottetown, Prince Edward Island.

E. H. Beer, Secy.

New Brunswick Board of Fire Underwriters,

Main Office: St. Johns, Newfoundland.

R. G. Asn, Secy.

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. THE MODERN HOSPITAL will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

Should the Hospital Submit to Inspections by Nongovernmental Agencies?

It has been said that this is a day of inspections. The institution receiving aid from a state or city government is often subjected to routine inspections to satisfy the state or city that the money it contributes is wisely spent. It is true that trained hospital executives often do not relish this inspection, because they recognize a lack of proper qualifications on the part of the inspectors themselves. This sort of inspection, at any rate, is welcomed by the hospital because it usually brings in its wake a continuance of needed contributions.

There are, however, a number of nongovernmental agencies that have undertaken to elevate hospital standards by rating them from the standpoint of efficiency as a result of one or more inspections. At times the hospital executive wonders whether the inspector is able, in so short a period of time, to form any adequate judgment as to the character of the hospital's work.

On the other hand, no hospital should object to any step which has as its basis the improvement of the care of the sick. The institution selfishly desires to have its name appear on the approved list of the inspecting agency. Nevertheless, the hospital has the power to exclude from its premises visiting inspectors who do not come with mandatory credentials. At the same time, the inspecting agency has an obligation to the institution to furnish qualified, courteous if not conciliatory inspectors—those who, by the exhibition of more than ordinary administrative knowledge, will add to the prestige of the association they represent.

THE MODERN HOSPITAL commends the efforts of the various national societies to improve hospital service and recognizes that they have done much good in this respect. It recommends to hospitals that they freely offer their facilities to those who come to examine their methods, because behind this effort is certainly a proper and commendatory motive.

Should the Doctor Be Permitted to Charge for Services to Ward or Part-Pay Private Cases?

One of the complaints that is often made by members of the visiting staff relates to their inability to charge for their services to ward or part-pay private cases. Indeed in some instances, it appears that the physicians' contention is not entirely unfair. There appears to be a time-honored custom in hospitals generally to prohibit a

physician from charging a fee for the treatment of ward patients. In most localities this appears to be a wise rule. It may be said to be almost axiomatic that the physician should not be permitted to charge the patient who does not recompense the hospital for the full cost of the services. To permit a physician to accept a fee from a patient whom the hospital is treating free is unjust to the hospital.

In some localities a new nomenclature has been adopted. This subdivides public ward patients into two classes—those who are paying below cost rates and those who will equal or exceed the expenses entailed by the patient's presence in the ward. In the latter group a physician is permitted to charge a fee not to exceed a certain maximum rate set by the hospital. The patient receives a favorable position in the ward, a slight concession as to visitors and a somewhat more desirable diet compared with that received by general ward patients. Outside of minor practical difficulties, chiefly relating to an undesirable class distinction, this plan has worked well. In semi-private wards physicians are usually permitted to charge a fee if the hospital is receiving full pay for the patients' treatment there. This appears to be just.

In other instances, a policy exists that permits semi-private patients to occupy beds in these wards on a part-pay basis. They should not be charged a fee by their attending physicians if adherence to the rule just mentioned is considered just. The hospital should endeavor, of course, to be absolutely fair to the physician, to the patients and to the community. Remembering its obligation to the community, it should not allow the payment of a physician's fee to work an economic unfairness to the community or to itself.

What Should Be the Relation of the Coroner to the Hospital?

All hospitals must have some dealings with the office of the coroner. It should be recognized at the outset that the function of the coroner's office is, in a general way, to investigate the cause of death in instances concerning which there is any doubt as to the existence of foul play. This lack of fair dealing may vary from actual death from criminal assault to loss of life as a result of malpractice on the part of unethical doctors.

In the light of present day developments, the coroner sometimes is called upon to fix the responsibility for the death of a worker when industrial concerns fail to adopt proper safeguards for protecting the lives of their employees. In other words, the coroner's court serves as a clearing house to separate trivial cases from those that should be brought to the attention of a grand jury.

The hospital, of course, is interested not only in carrying on its own scientific work but also in serving its community. The relationship between the hospital and the coroner should certainly be one of helpful cooperation.

Although in some instances, it may seem unnecessary to report to this officer all deaths that occur within twenty-four hours after the admission of the patient, yet, to follow such a policy assiduously is to protect the hospital against unjust claims or suspicions. If the hospital willingly reports all cases concerning which there is the least suspicion as to the cause of death, by so doing, it announces to the community that it has nothing to hide and that it is voluntarily cooperating with a legalized agency that professes to safeguard the interests of the public.

Some institutions cooperate to the extent of reporting to the coroner's office deaths from easily ascribable causes in which there is a history of injury at some recent or even remote time. Old fractures of long bones, head injuries and even cases where a patient has been subjected to considerable violence without discernible injury to vital structures are brought to the coroner's notice.

The hospital should be on its guard to secure an antemortem statement from patients who have been subjected to assault or malpractice before they become unconscious. Carelessness on the part of the hospital in this respect may lead to the loss of an opportunity to aid in bringing guilty persons to justice. It is a well known fact that a properly executed antemortem statement is considered to be of vital testimonial importance in criminal cases. Hence, it is far better to report too many cases to the coroner's office than to fail to report one in which the wheels of justice are blocked because of carelessness or indifference on the part of any member of the hospital's personnel.

Some institutions even report to the coroner an operative table death, or a sudden death resulting from probable coronary blockage or acute cardiac dilatation. It would seem wise for all institutions, instead of adopting a policy that might be construed as obstructive, to recognize that the coroner's office and the hospital can be of mutual aid to each other in carrying on their work.

One objection often made by the hospital is that the coroner's office is not cooperative in its effort to maintain a high percentage of postmortem examinations. One institution has overcome this difficulty by securing the appointment of one of its resident officers as deputy coroner's physician. This doctor acts officially in the performance of such intrahospital postmortems. A protocol covering the gross anatomical as well as histological findings is forwarded to the coroner's office in each case. This practice serves to complete the coroner's records and to render his diagnoses scientifically correct as well as to protect his office against present or future fanciful claims.

How Can Vermin Be Eradicated?

This question asked by the superintendent of a Southern hospital had particular reference to the eradication of roaches and bed bugs. There are many preparations on the market that claim to be efficient in the elimination of vermin. Unfortunately for the hospital, the most of these products range in cost from \$1.50 to \$2.25 a gallon. This price appears exorbitant, and indeed in a hospital of any size a considerable amount of money is required for the purchase of these chemicals.

Efficient roach and bed bug exterminators have several requisites. They must be effectual and cheap. They must not stain linens and must not be dangerously inflammable. Many of these proprietary combinations are built around a noninflammable base, which is said by those who distribute the product to be rather expensive.

One institution uses the following preparation which it manufactures in large quantities in its own drug depart-

ment at a cost of about thirty-five cents a gallon: cresol, forty ounces; oil of myrbane, three ounces; coal oil, sufficient to make five gallons. This preparation is efficient for flies, roaches and bed bugs. It is not particularly dangerous from the standpoint of fire if properly used, and it will not harm the hands unless used in concentrated solution.

Almost any such preparation is likely to injure the wire of screen doors and windows if used continuously. In such a case, however, the good it does considerably over-balances the harm. A requisite of success in the use of almost any solution, homemade or proprietary, is the proper method of application. A galvanized iron tank with a capacity of from one to two gallons, with an air pump attached and supplied with a proper spraying nozzle makes a satisfactory outfit. A hand pump that needs to be continuously operated while the outfit is in use does not develop pressure to vaporize the fluid sufficiently for the best results. The outfit described, with the tank with sufficient hose slung across the shoulder of the operator can be easily operated and is deadly for the vermin. The skilled operator may with this solution even remove flies from white bed spreads without soiling the linen.

A bed infested with vermin should be removed from the ward, and as many vermin as possible dislodged by pounding the springs and helicals with a padded club. The solution is then used in order to reach the finer bed joints and crevices.

In some institutions, during the summer months particularly, the work of vermin extermination is assigned to one man who becomes expert in doing this work. It need only be added that cleanliness, frequent painting of wards and rooms, the removal of wall moldings and imperfect flooring and the closing of all crevices with plaster are necessary and effectual steps in any campaign of vermin eradication.

What Are the Duties of the Hospital Medical Director?

When the hospital's administrative organization is headed by a lay superintendent, some officer who is in possession of a medical training appears necessary. In smaller institutions, these medical duties often are assigned to the chief resident physician. This individual may be an intern who has recently finished his period of hospital residency. This practice is followed because it is presupposed that a former intern will be informed concerning such details of the hospital's work as the technique for the admission of patients, the arrangement of intern schedules and the supervision of the hospital's medical services during the absence of the visiting chiefs.

Again, in lieu of the chief resident physician, there may be found a member of the staff who has been designated as medical director. This officer is expected to be responsible to the board of trustees through, not around, the superintendent for the proper medical conduct of the hospital. To him come for solution such problems as the regulation of quarantines, the conduct of dispensaries, the initiation and enforcement of the proper technique in the various hospital departments and the direction of the work of the interns.

Again, there may be a combination of these two systems whereby a recently graduated intern is designated as chief resident physician, acting for the medical director in his absence. In either instance it is necessary for the members of the board of trustees and their executive officer, the superintendent, to have available the services of one

from whom they may secure sound medical advice on problems as they arise. It would appear that this service in small hospitals, could be fully covered by a part-time medical director. On the other hand, unless this officer is continually within easy call, it appears wise to designate some resident physician as the person in medical charge during the absence of the part-time director. And there need be no misunderstanding between the lay superintendent and the medical director because of the more or less clear-cut line which separates their duties. The time has long since passed when a hospital superintendent without medical training is expected to be able intelligently to decide the many questions having a distinct medical bearing that constantly arise.

Should the Hospital Pay the Salary of Employees Injured on Duty?

In the institution asking this question, the following dilemma arose: A cook having fallen on the kitchen floor and having sustained by the fall a sacro-iliac strain was admitted to the hospital and a plaster cast applied. He was somewhat refractory to treatment and was finally discharged in not an entirely relieved condition. He returned to work, but complained about his treatment by the hospital and was generally unsatisfactory. He demanded that the hospital pay his salary in full while he was ill. This the institution did for two months. In the meantime, without the knowledge of the hospital, he applied for compensation and received an award of \$13 a week for ten weeks. Hence, the injury was to the financial advantage, at least, of the employee.

In some states, there is a ruling that compensation does not begin until two weeks have elapsed since the injury. It would seem that during this time that it is the duty of the institution to pay the salary and perhaps furnish treatment to an injured employee. At the conclusion of this period, if the hospital is informed that the employee is seeking compensation, it probably has no obligation to continue the payment of his salary.

A difficulty arises at times in ascertaining the connection between a reported injury or sickness, and the fact that the patient was employed by the institution. Reference is here made to indefinite joint symptomatology, the development of tuberculosis or of other catarrhal conditions by those who are working in an overheated atmosphere, as well as any other unusual combination of circumstances that might possibly reflect unfavorably on the patient's health.

The hospital must, of course, indulge in no unfair dealing with its employees. Indeed, it is the policy of institutions generally to err on the side of too generously caring for their workers rather than to enforce the letter of the law in this respect. Certainly, injured employees should not receive at the same time both compensation and their salaries. A definite understanding between the compensation court and the hospital executive should exist to prevent this from happening.

What Is the Justification of the Occupational Clinic?

In institutions that have developed a department for the prevention of disease, the occupational clinic finds a proper place. To it come patients who are in no way ill but who are desirous of learning the effect of their occupation upon their health generally. Workers in lead, such as employees in paint factories, battery workers and electricians learn of this occupational hazard and ask

advice as to methods of protecting themselves and their families against any damage to their healths that may be incident to their occupations.

This clinic also assumes a decidedly preventive aspect along another line. In one city where an active campaign against the handling of food by venereally infected and tuberculous individuals was being carried on, many hundreds of these workers were examined in an occupational clinic. Surprising results were encountered. Even workers in high grade restaurants and hotels furnished their quota of spirochaetal and gonococcal infections. Infection of the lungs and other tissues with Koch's bacillus was all too commonly observed.

If an occupational clinic performed no other function than to safeguard the public against the transmission of disease by those who handle foods, it would be worth while. This, however, cannot be carried out to its fullest extent without cooperation between the hospital and the health authorities of the community. To require a food handler's certificate before an engagement as a cook or a waiter can be secured would be to force such applicants to come to the hospital to secure a clean bill of health. This would appear to be a preventive medicine function of the institution, to meet which but a small amount of money and equipment is needed.

Should the Superintendent Interview Nurses When the Directress Is Not Present?

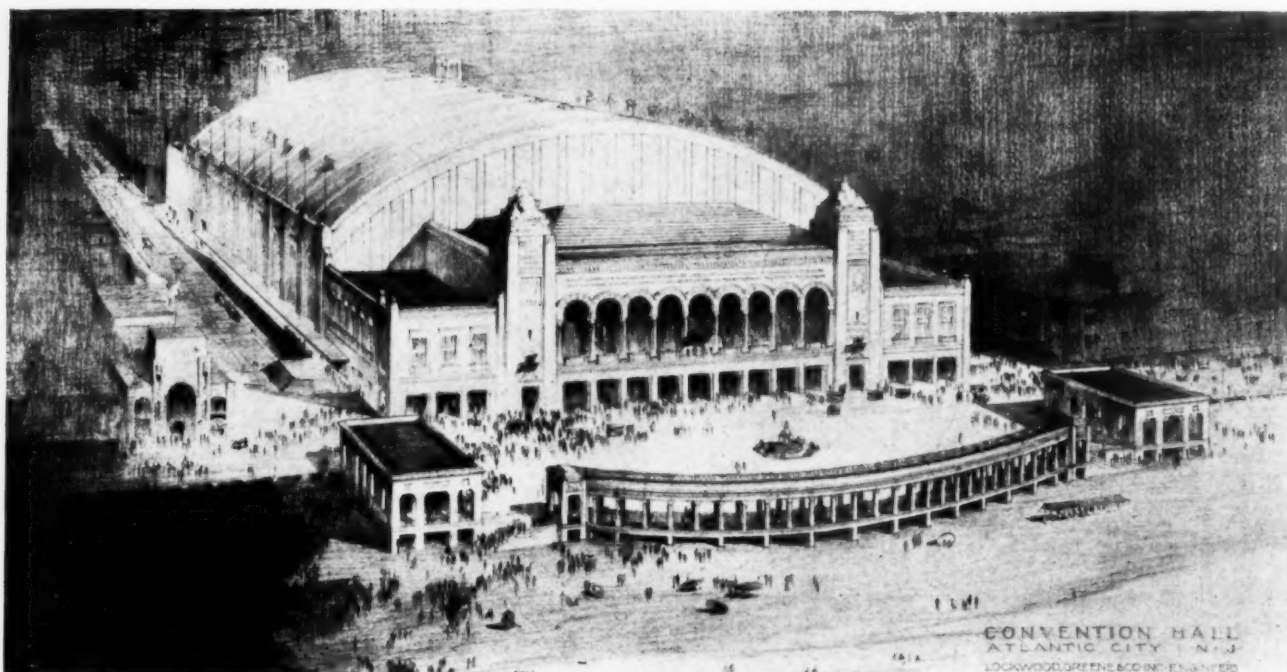
This question was asked by a directress of nurses who was annoyed and humiliated when the superintendent of the hospital requested pupil and graduate nurses to come to his office in order that he might interview them regarding certain matters concerning their work in the wards. The directress of nurses was rarely present.

Such a happening would seem almost unbelievable were it not so common in certain hospitals in this country. The superintendent mentioned forgot a fundamental rule of administration. He neglected to observe the basic rule that lines of authority must be rigidly maintained and that while he has the power to send for a nurse he does not have the right to do so. To carry on the work of any organization, whether it be a hospital or an industrial concern, without adhering to routine administrative principles is to court friction and inefficiency.

In the instance cited, the dignity and the authority of the directress of nurses could not be maintained in the presence of such a practice. If the administrator had desired to question a nurse concerning her work and he felt that the superintendent of nurses was not capable of securing the information for him, he should have requested her to bring to his office the nurse in question. Should a reprimand appear necessary as a result of this interview, it should come from the directress of nurses and not from the superintendent of the hospital.

It would be a fine thing, indeed, if a blue print of organization could be hung on the wall of every hospital and, finer still, if the superintendent, directress of nurses and all other heads of departments would rigidly adhere to the routine paths of routing personal and official orders as indicated in this document.

This applies not only to the superintendent and to the directress of nurses, but to the members of the board of trustees who sometimes in their zeal to improve the work of the hospital forget to hold high the hands of departmental heads whom they have engaged and whom they should support.



The new auditorium at Atlantic City where delegates will assemble.

Finishing Touches Are Added to Convention Plans

WITH the exception of a few speakers who are yet to be announced, the program of the American Hospital Association convention in Atlantic City, June 17 to June 21, is complete and will be followed essentially as it is presented here. The finishing touches are being added to the convention plans and last minute information indicates that the convention will be successful in every detail. Dr. René Sand, chairman of the international executive committee of the International Hospital Congress, which is meeting in Atlantic City, June 13, 14 and 15, is to give the keynote address and Dr. Aladar von Soos, Royal Hungarian University Clinics, Budapest, Hungary, is scheduled to speak, as are other leaders in the hospital and public health fields. The program follows:

Monday Afternoon, June 17

General session: Dr. Louis H. Burlingham, president, American Hospital Association, Barnes Hospital, St. Louis, presiding.

"Hospital Problems Arising Out of the Care of Highway Cases," Dr. Emil Frankel, director of research, State Department of Institutions and Agencies, Trenton, N. J.

"The Relationships of Hospitals to the Health Departments of Large Cities," Dr. Arnold H. Kegel, commissioner of health, City Department of Health, Chicago.

"Institutional Care of Tuberculosis in Childhood," Dr. B. S. Pollak, Hudson County Tuberculosis Hospital and Sanatorium, Secaucus, N. J.

"Mental Hospitals."

"European Hospitals."

Committee reports.

Monday Evening, June 17

General session and reception of delegates: Dr. Louis H. Burlingham, presiding.

Invocation, Dr. J. H. Bauernfeind, president, Protestant Hospital Association, Evangelical Deaconess Hospital, Chicago.

Address of welcome, Hon. M. F. Larson, governor of New Jersey.

Response to address of welcome, Dr. Joseph C. Doane, Jewish Hospital, Philadelphia.

Keynote address, Dr. René Sand, chairman, international executive committee, International Hospital Congress, Paris, France.

Presidential address, Dr. Louis H. Burlingham.

In the receiving line, International Hospital Relations Committee members, officers of the American Hospital Association and distinguished guests.

Music.

Tuesday Morning, June 18

Open forums on administration: Asa S. Bacon, Presbyterian Hospital, Chicago, coordinator; Dr. W. L. Babcock, Grace Hospital, Detroit, associate coordinator; Robert Jolly, Baptist Hospital, Houston, Texas.

Social service section: Ruth E. Lewis, assistant director of social work, Washington University Hospital, St. Louis, chairman; Helen Beckley, American Association of Hospital Social Workers, Chicago, secretary.

Greetings from Dr. Christopher G. Parnall, Rochester General Hospital, Rochester, N. Y., president-elect, American Hospital Association.

"Functions of Hospital Social Service."

"Should Social Work in Hospitals Be Confined to Free



Dr. Louis H. Burlingham, president of the association.

or Part-Pay Patients? Is a Patient's Financial Rating Alone a Sound Basis for Reference to Social Service?" Ora M. Lewis, Massachusetts General Hospital, Boston.

Reports of districts and committees.

Reports of executive secretary and educational secretary.

Election of officers.

Dinner meeting of social service section.

Tuesday Afternoon, June 18

Out-patient section: Dr. George W. DuVall, Central Free Dispensary, Chicago, chairman; Dr. Donald C. Smelzer, The Chas. T. Miller Hospital, Inc., St. Paul, Minn., secretary.

Teaching hospital section: Paul H. Fesler, University of Minnesota Hospital, Minneapolis, Minn., chairman; Dr. R. C. Buerki, State of Wisconsin General Hospital, Madison, secretary.

Greetings, Dr. Louis H. Burlingham, president, American Hospital Association.

"The Dietary Department of the Teaching Hospital," Anna E. Boller, president, American Dietetic Association, Chicago.

"The Social Service Department of the Teaching Hospital," Grace Ferguson, Barnes Hospital, St. Louis, representing the American Association of Hospital Social Workers.

"The Number of Teaching Beds in the United States," Dean C. R. Bardeen, University of Wisconsin, Madison.

"The Grading Committee Program as It Relates to Teaching Hospitals," Mary Gladwin, St. Mary's Hospital, Rochester, Minn.

"Teaching Hospitals of Europe."

Election of officers.

Trustees section: Arthur A. Fleisher, president, board of trustees, Jewish Hospital, Philadelphia, chairman.

"Trusteeship," Philip C. Staib, president, Bergen County Hospital, Ridgewood, N. J.

"The Aims of the Civic Hospital Association," Ethel Kincaid Greenbaum, president, Civic Hospital Association of Chicago, Chicago.

"The Help the Trustees Can Give to the Superintendent," Dr. C. C. Burlingame, Joint Administrative Board, Columbia Presbyterian Medical Center, New York City.

"Publicity and the Best Type of Publicity for Hospitals and Kindred Institutions," Samuel S. Schwab, editor, *Philadelphia Public Ledger*, Philadelphia.

Election of officers.

Tuesday Evening, June 18

Joint session: National League of Nursing Education and the American Hospital Association.

"Nursing Education From the Viewpoint of the Hospital Trustee," Richard P. Borden, president, board of trustees, Union Hospital, Fall River, Mass.

"Nursing Education From the Viewpoint of the Hospital Superintendent," Dr. B. W. Black, Highland Hospital, Oakland, Calif.



Dr. Christopher G. Parnall, the president-elect.



Dr. Bert W. Caldwell, executive secretary.

Wednesday Morning, June 19

Open forums on special hospital problems: Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, N. Y., coordinator; Dr. John F. Bresnahan, St. Mark's Hospital, New York City, associate coordinator. Round table on out-patient work, Dr. Michael M. Davis, director for medical services, Julius Rosenwald Fund, Chicago.

Wednesday Afternoon, June 19

Construction section: Dr. George O'Hanlon, Jersey City Hospital, Jersey City, N. J., chairman; Oliver H. Bartine, hospital consultant, New York City, secretary.

Report of the committee on hospital construction, Dr. S. S. Goldwater, hospital consultant, New York City.

General discussion.

New Type Hospital (Lantern Slides), F. T. H. Bacon, consulting building engineer, New York City.

Discussion, A. J. Swanson, Toronto Western Hospital, Toronto, Canada.

Nurses' Home, James R. Mays, Homeopathic Hospital of Rhode Island, Providence, R. I.

General discussion.

Election of officers.

Administration section: Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y., chairman; Clarence H. Baum, Lake View Hospital, Danville, Ill., secretary.

"The Need of a Research Bureau for the Hospital Field," Dr. Carl E. McCombs, Bureau of Municipal Research, New York City.

Discussion, Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago; Col. R. E. Longan, Baltimore City

Hospitals, Baltimore; Miss Sydnor L. Walker, Laura Spelman Rockefeller Fund, New York City.

"The Meaning of Hospital Costs," Dr. C.-E. A. Winslow, School of Public Health, Yale University, representing the Committee on the Cost of Medical Care.

Discussion, Dr. Malcolm T. MacEachern, director, Hospital Activities, American College of Surgeons, Chicago; Frank E. Chapman, Mt. Sinai Hospital, Cleveland; Dr. Donald M. Morrill, Blodgett Memorial Hospital, Grand Rapids, Mich.

"What the Foundations Are Doing for American Hospitals," John A. McNamara, executive editor, *THE MODERN HOSPITAL*, Chicago.

Discussion, Dr. W. S. Rankin, director, Hospital Section, Duke Foundation, Charlotte, N. C.; Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago; Henry J. Southmayd, Commonwealth Fund, New York City.

"Present Status and Future Needs in Institutional Care of Convalescents," Dr. E. H. Lewinski Corwin, United Hospital Fund, New York City.

Discussion, Dr. George Frederick Clover, St. Luke's Hospital, New York City; Dr. Ralph B. Seem, University of Chicago Hospitals, Chicago; Dr. A. C. Bachmeyer, Cincinnati General Hospital, Cincinnati.

"Place of the Hospital in the Promotion of Public Health Programs," Dr. Matthias Nicoll, Jr., New York State Commissioner of Health, Albany, N. Y.

Discussion, Dr. William J. Ellis, commissioner, State Department of Institutions and Agencies, Trenton, N. J.; Dr. Walter S. Goodale, Buffalo City Hospital, Buffalo, N. Y.; Dr. R. C. Buerki, State of Wisconsin General Hospital, Madison.

Election of officers.

Wednesday Evening, June 19

Annual banquet and ball: Chelsea Hotel. Dr. Louis H. Burlingham, master of ceremonies.

Music.

Speaker of the evening, Edwin S. Embree, president, Julius Rosenwald Fund, Chicago.



Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y., chairman of the administration section.

Thursday Morning, June 20

Open forums on the small hospital: E. S. Gilmore, Wesley Memorial Hospital, Chicago, coordinator; Howard E. Bishop, Robert Packer Hospital, Sayre, Pa., associate coordinator; G. W. Olson, California Lutheran Hospital, Los Angeles.

Thursday Afternoon, June 20

Tuberculosis section: Dr. Glenford L. Bellis, Muirdale Sanatorium, Wauwatosa, Wis., chairman; Dr. H. J. Corper, National Jewish Hospital, Denver, Colo., secretary.

"Sanatorium Buildings—100-Bed Unit," Edgar A. Stubenrauch, architect, Sheboygan, Wis.

Discussion, T. B. Kidner, hospital consultant, New York City.

"Business Administration," Dr. H. A. Pattison, Potts Memorial Hospital, Inc., Livingston, N. Y.

"Medical Administration."

Discussion, Dr. Arnold Shamaskin, Montefiore Country Sanatorium, Bedford Hills, N. Y.

"Sanatorium Objectives."

Discussion, Dr. W. H. Ordway, physician in charge, Metropolitan Life Insurance Company Sanatorium, Mt. McGregor, N. Y.

Election of officers.

Small hospital section: G. W. Olson, California Lutheran Hospital, Los Angeles, chairman; J. O. Sexson, Good Samaritan Hospital, Phoenix, Ariz., secretary.

"Practical Methods of Financing the Small Hospital—(a) Its Plant and Equipment; (b) Its Operation and Maintenance; (c) Its Growth and Developments; (d) Paying Off the Hospital Debt," Clarence H. Baum, Lake View Hospital, Danville, Ill.

"Responsibility of the Community for the Cost of Hospital Care," J. J. Weber, New Haven, Conn.

"Hospitals and Modern Credit Business Practice—(a) Should Hospital Service Be Sold on the Installment Plan? (b) Do Modern Standards of Living Force Installment Buying in All Lines and Is It True That Much Complaining of High Cost of Hospital Service Is Due to This Commodity's Not Being Purchasable on a Pay-As-You-Earn Basis?" Ernest G. McKay, Arnot Ogden Memorial Hospital, Elmira, N. Y.

"How Social Workers Aid in Solving Some Problems of Small Hospitals."

Election of officers.

Dietetic section: Bertha E. Beecher, Christ Hospital, Cincinnati, chairman; Margaret S. Gillam, University Hospital, Ann Arbor, Mich., secretary.

Report of the committee on dietary service and equipment, Mary A. Foley, Kahler Corporation, Rochester, Minn., chairman.

"What the Dietary Department Should Mean to a Hospital," Dr. Joseph C. Doane.

"Organization of the Dietary Department in the Large Hospital," Dr. Aladar von Soos.

Special Diets—a Symposium.

"The Doctor and Special Diets," Dr. H. A. Shaw, Pittsburgh.

"The Dietitian and Special Diets," Helen Gilson, dietitian, Pennsylvania Hospital, Philadelphia.

"The Student Nurse and Special Diets," Sara Ann Cassell, principal, school of nursing, Montefiore Hospital, Pittsburgh.

Round table, conducted by Bertha Wood, consulting dietitian, East Northfield, Mass.

Election of officers.

Thursday Evening, June 20

Nursing section: Carrie M. Hall, superintendent of nurses, Peter Bent Brigham Hospital, Boston, chairman; Grace Allison, Samaritan Hospital, Troy, N. Y., secretary.

"The Grading Program," Dr. May Ayres Burgess, director, Committee on the Grading of Nursing Schools, New York City.

"What Constitutes the Faculty of a School of Nursing?" Marian Rottman, R.N., director of nursing service, Bellevue and Allied Hospitals, New York City.

"The Effect of Raised Educational Standards of Students and Faculty on Both Schools of Nursing and Hospitals," Ada Belle McCleery, R.N., Evanston Hospital, Evanston, Ill.

"What Background of Education and Experience Should We Expect for Members of Faculties of Schools of Nursing?" Margaret Tracy, R.N., assistant professor, Yale University School of Nursing, New Haven, Conn.

Election of officers.

Friday Morning, June 21

General session:

Reports.

New business.

Unfinished business.

Installation of officers.

Adjournment.



Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn.

Alphabetical List of Exhibitors at Atlantic City Convention

	Booth No.		Booth No.
Acme International X-Ray Co. 711 W. Lake St., Chicago X-ray equipment.	315, 317, 319	Britesun, Inc. 3735 Belmont Ave., Chicago Electro physiotherapy equipment.	329
Allegheny Steel Co. Brackenridge, Pa. Allegheny metal, sheets, plates, bars, billets, tubes and rivets.	325	Campbell Refrigerator Co. 176 W. Adams St., Chicago Refrigerators for all purposes.	103
Allison Co., W. D. 915 N. Alabama St., Indianapolis, Ind. Office equipment.	636	Cash, Inc., J. & J. 220 S. Chestnut St., South Norwalk, Conn. Woven names, initial linen marking letters, friction bath towels, bath gloves and wash cloths.	44
Altro Work Shops, Ind. 1921 Jennings St., New York City Hospital garments.	33, 122	Castle Co., Wilmot Rochester, N. Y. Sterilizers.	628
Aluminum Cooking Utensil Co. New Kensington, Pa. "Wear-Ever" aluminum cooking utensils.	226, 228	Celotex Company 919 N. Michigan, Chicago Acousti-Celotex.	631
Amcoin Coffee System, Inc. 53 Illinois St., Buffalo, N. Y. All glass interior coffee system.	133	Champion Dishwashing Machine Co. 15th and Bloomfield Sts., Hoboken, N. J. Dishwashing machines.	4
American Dietetic Association 25 E. Washington St., Chicago Publication.	135	Chicago Tea Bag Co. 845 Washington Blvd., Chicago Tea bags.	131
American Honey Producers League Laramie, Wyo.	54	Clark Co., A. M. 1907 W. Harrison St., Chicago Bedside tables, Bacon lights, chairs, lockers, filing cabinets.	125
American Journal of Nursing, The 370 Seventh Ave., New York City Publication.	523	Clay-Adams Co. 117 E. 24th St., New York City Skeletons, charts and models.	521
American Laundry Machinery Co. Norwood Station, Cincinnati American Perry washer, American Perry extractor, Stand- ard Cascade washer, Eagle air drive presses, Tahara burn- ishing machine, two roll return apron flat work ironers, drying tumbler, blanket dryer.	30, 32, 34, 36, 38, 40	Colgate-Palmolive-Peet Co. 919 N. Michigan, Chicago Soaps.	13
American Sterilizer Co. Erie, Pa. Sterilizers and hospital equipment.	518, 520	Colson Company, The Elyria, Ohio Wheel chairs, stretchers, tray trucks, book trucks, inhal- ators, rubber bumpers, several types of trucks suitable for hospital use, casters.	533, 535, 537, 539, 541
Anstice & Co., Josiah 97 Humboldt St., Rochester, N. Y. Sterling slicers, Sterling peelers.	637	Colt's Patent Fire Arms Mfg. Co. Hartford, Conn. Dishwashing machines.	411, 413
Antell & Jones, Inc. Philadelphia	17	Connecticut Telephone & Electric Co. Meriden, Conn. Clock and fire alarm equipment, hospital signaling equip- ment, doctor paging equipment.	324
Applegate Chemical Co. 5632 Harper Ave., Chicago Indelible ink linen marker.	543	Continental Chemical Corporation Watseka, Ill. Car-Na-Var and Rubber-Var (floor treatments), Clean-O-Shine and De-Ter-Go (floor cleaners), Baby-Balm liquid soap, Sterizol and other disinfectants, polishes, cleaners, deodorizers, insecticides, soft soaps, soap dis- pensers, spray pumps and lambs' wool mcps.	232
Armstrong Cork Co. Lancaster, Pa. Armstrong linoleum and other products.	20	Crane Co. 836 S. Michigan Ave., Chicago Plumbing fixtures.	422
Atlas Copper & Brass Mfg. Co. 2734 High St., Chicago Jewell polar water stills.	423, 425	Cunningham, Son & Co., James Rochester, N. Y. Ambulance	16, 18
Baker Linen Co., H. W. 41 Worth St., New York City Sheets, pillow cases, blankets, bath and face towels, table linens, towelings.	203	Davis Co., F. A. 1914 Cherry St., Philadelphia Books.	140
Bard-Parker Co., Inc. 369 Lexington Ave., New York City Detachable blade knives.	501	Davis Co., R. B. Hoboken, N. J. Cocomalt.	435
Battle Creek Food Co. Battle Creek, Mich. Battle Creek Sanitarium health foods.	503	Deknatel & Son, J. A. 222nd St. and 96th Ave., Queens Village, Long Island, N. Y. Nursery name necklace, Morgenthaler bed for premature infants.	630
Becton, Dickinson & Co. Rutherford, N. J. B-D thermometers, syringes, needles and hospital specialties.	410, 412	Denoyer-Geppert Co. 5235 Ravenswood Ave., Chicago Anatomical models, charts, manikins, stereopticons, slides, skeletons.	611
BiSoDol Co., Inc., The 130 Bristol St., New Haven, Conn. BiSoDol.	526		
Blakeslee & Co., G. S. 1900 S. 52nd Ave., Chicago Dishwashers.	130, 132		

	Booth No.		Booth No.
DePuy Manufacturing Co. Warsaw, Ind. Splints and overhead extension frame.	29	Goodyear Tire & Rubber Co., Inc. Akron, Ohio Rubber floor covering material.	49
Deshell Laboratories, Inc. 536 Lake Shore Drive, Chicago Petrolagar, emulsion of mineral and agar-agar.	318, 320	Greenpoint Metallic Bed Co. 226 Franklin, Brooklyn, N. Y. Beds.	105, 107, 109
Detroit-Michigan Stove Co. 6900 Jefferson Ave. E., Detroit, Mich. Garland heavy duty ranges and broilers.	643, 645	Greppin Corporation 513 W. Windsor St., Glendale, Calif. Surgical lighting equipment.	47
Domestic Electric Co. 7209 St. Clair Ave., Cleveland Claritors.	124	Griswoldville Mfg. Co. 56 Worth St., New York City Absorbent gauze, crinoline and bandages.	512
Doniger & Co., Inc., S. 23 E. 21st St., New York City X-acto Luer syringes and surgical instruments.	56	Gumpert Co., Inc., S. Bush Terminal, Brooklyn, N. Y. Desserts, milk chocolate and Punch (beverage powder).	231, 233
Dougherty & Co., H. D. 17th St. and Indiana Ave., Philadelphia Steel hospital furniture, beds and bedding.	403, 405, 407	Hall & Sons, Frank A. 118 Baxter St., New York City Hospital beds and bedding.	307, 309, 406, 408
Dougherty & Sons, Inc., W. F. 1009 Arch St., Philadelphia Kitchen equipment.	615, 617	Hankins Rubber Co. Massillon, Ohio Seamless rubber goods.	52
Duriron Co., Inc., The P. O. Box 1019, Dayton, Ohio Duriron acid resisting pipe and exhaust fans.	609	Hanovia Chemical & Mfg. Co. Chestnut St., Newark, N. J. Quartz lamps, quartz light therapy.	507
Eastman Kodak Co., Medical Division Rochester, N. Y. Motion picture apparatus and x-ray supplies.	629	Heidbrink Co. 2633 Fourth Ave. S., Minneapolis, Minn. Gas machines.	204, 206
Edison Electric Appliance Co. 5600 W. Taylor St., Chicago Electric cooking equipment.	648, 650	Henney Motor Co. Freeport, Ill. Ambulance.	9
Edwards & Co., Inc. New York City	21	Hill-Rom Co. Batesville, Ind.	41, 43
Eisenstein & Co., Inc., H. 88 Essex St., New York City Anatomical goods, medical books, charts, teaching supplies.	528	Hobart Manufacturing Co. 48-68 Penn Ave., Troy, Ohio Hobart mixing machines and Crescent dishwashers.	223, 225, 227, 229
Electric Storage Battery Co., The 19th St. and Allegheny Ave., Philadelphia Exide batteries for emergency lighting.	509	Holtzer-Cabot Electric Co. 125 Amory St., Roxbury, Mass. Hospital signal systems.	436
Englander Spring Bed Co. 100 W. 32nd St., New York City Hospital beds, bedding and furniture.	536, 538	Horlick's Malted Milk Corporation Racine, Wis. Horlick's malted milk, Horlick's Maltose-Dextrin and Du-more electric mixer.	134
Evaporated Milk Assn. Chicago	45	Hospital Import Corporation 48 E. 25th St., New York City Hospital supplies, hospital furniture, specialties, laboratory supplies, enameled glass and rubber goods, and equipment accessories.	114
Faichney Instrument Corporation Watertown, N. Y. Clinical thermometers, hypodermic needles and syringes, and surgical instruments.	327	Hospital Management 537 S. Dearborn St., Chicago Publication.	3
Faspray Corporation Red Bank, N. J. Dishwashing machines.	639	Hospital Standard Publishing Co. 40-42 S. Paca St., Baltimore, Md. Case records, charts, record books, case record supplies.	622
Faultless Caster Co. Evansville, Ind. Casters.	647	Hospital Topics and Buyer 28 E. Huron St., Chicago Publication.	506
Fengel Corporation, The 239 Fourth Ave., New York City Hospital, surgical, laboratory supplies including enameled ware, glassware, surgical instruments, rubber goods, thermometers, hypodermic syringes and needles.	500	Huntington Laboratories, Inc. Huntington, Ind. "Levernier" foot pedal soap dispensers, Baby-San dispensers, liquid surgical soap, Baby-San liquid castile, floor wax, scrubbing compounds, cresol compounds.	321
Fillman Co., John W. 1020 Filbert St., Philadelphia Linens, blankets, gowns, dry goods and hospital specialties, also loom.	303, 305, 402, 404	Hygienic Fibre Co. 227 Fulton St., New York City Cotton gauze and surgical dressings.	115, 117
Finnell System, Inc. Elkhart, Ind. Electric scrubbing, waxing and polishing equipment.	610	International Hospital Equipment Co. 8 W. 40th St., New York City Surgical instruments, Operay multibeam light and Scanlan Balfour operating table.	10
Fisher, A. R. (R.N.) 100 W. 55th St., New York City Colon irrigation equipment.	616	International Nickel Co., Inc. 67 Wall St., New York City Monel metal products.	527, 529
Ford Sales Co. The J. B. Wyandotte, Mich. "Wyandotte" Yellow Hoop, "Wyandotte" Detergent and "Wyandotte" Cleaner and Cleanser.	613	Jacobs Bros. 40 E. 34th St., New York City Nurses' uniforms.	234
Formica Insulation Co. 4635 Spring Grove Ave., Cincinnati Table and desk coverings.	607	Jamison Sempie Co. 419 Fourth Ave., New York City Surgical supplies and equipment.	326, 328
Gaige Signal Corporation New York City	618, 620	Johns-Manville Corporation 292 Madison Ave. at 41st St., New York City Acoustical correction, Asbestile, asbestos wood.	129
Gendron Wheel Co. 793 Superior St., Toledo, Ohio Wheel chairs, wheel stretchers and hospital trucks.	123		

	Booth No.		Booth No.
Johnson & Johnson, Inc. New Brunswick, N. J. Surgical dressings, ligatures, sutures.	119, 218	Modern Hospital Publishing Co. 919 North Michigan, Chicago Publication.	308
Judd Co., Inc., H. L. 87 Chambers St., New York City Cubicle curtain equipment.	58	Morris Hospital Supply Co. 112 E. 19th St., New York City Hospital supplies.	427
Kansas City Oxygen Gas Co. 2012 Grand Ave., Kansas City, Mo. Nitrous oxid, oxygen, carbon dioxide, ethylene, hydrogen and gas apparatus.	508	Mott Co., Inc., J. L. Trenton, N. J. Plumbing fixtures.	24, 26
Kaufmann & Co., Henry L. 301 Congress St., Boston No-Rinkle rubber sheets, hospital supplies and specialties.	306	Mueller & Co., V. 1835 W. Van Buren St., Chicago Surgical instruments, baby incubator, ether vapor and suc- tion apparatus, electric bone engines, Operay multibeam light.	137, 139
Keever Starch Co. Columbus, Ohio Sizing for use in hospital laundries.	6	Mulford Co., H. K. Broad and Wallace, Philadelphia M.A.B. antivenin, insulin and biological products.	302, 304
Kelley-Koett Mfg. Co., Inc. Covington, Ky. X-ray apparatus and physical therapy equipment.	600, 601	National Carbon Co., Inc. Cleveland Eveready sunshine carbon arc lamp.	104
Kellogg Company Battle Creek, Mich. Kellogg cereals, corn flakes, Pep bran flakes, all bran, rice krispies, Kaffee Hag coffee.	100	National Enameling & Stamping Co. First Wisconsin National Bank Building, Milwaukee Monel metal hospital utensils.	531
Kent Co., Inc., The 531 Dominick St., Rome, N. Y. Floor machines and vacuum cleaners.	8	National Lead Co. 111 Broadway, New York City Display of color charts and decorative service for hospitals.	623
Kny-Scheerer Corp., The 10-14 W. 25th St., New York City Surgical instruments, furniture and sterilizing apparatus.	236, 238	Neitzel Mfg. Co., Inc. Waterford, N. Y. Nurses' apparel and hospital garments.	429
Leonard-Rooke Company 468 Broad St., Providence, R. I. Thermostatic water mixing valves.	428, 430	Norton Door Closer Co. 2900 N. Western Ave., Chicago Door closers.	35
Lewis Mfg. Co. Walpole, Mass. "Curity" gauze, cotton and dressings, cellucotton.	314, 316	Oakite Products Co. 18 Thames St., New York City Industrial cleaning materials and methods.	5
Lewis, Samuel 73 Barclay St., New York City General cleaning supplies.	224	Ohio Chemical & Mfg. Co. 1177 Marquette St., N. E., Cleveland Gas and gas machines.	51
Lippincott Co., J. B. 227 S. Sixth St., Philadelphia Books and charts.	322	Olson & Co., Samuel 1238 Kostner Ave. N., Chicago Linen chutes, Universal pneumatic tube systems.	641
Lyons Sanitary Urn Co. 235 E. 44th St., New York City Liquid dispensers.	627	Onondaga Pottery Co. Syracuse, N. Y. Crockery and china.	106, 108, 110, 112
Macbeth Daylighting Co. 227 W. 17th St., New York City Apparatus for scientific production of daylight.	621	Perfect Caster Mfg. Co. 3517 E. 11th St., Long Beach, Calif.	632, 634
MacGregor Instrument Co. Needham, Mass. Surgical instruments and electric or water breast pumps.	22	Darnell institutional casters, Darnell silent cushion glides (formerly the Drake), Darnell noiseless glides, Darnell industrial casters.	
Macmillan Co., The 60 Fifth Ave., New York City Books.	2	Permutit Co., The 440 Fourth Ave., New York City Water softening and filtering equipment.	7
Maimin Co., H. 251 W. 19th St., New York City Gauze and bandage cutters.	514	Pfaltz & Bauer, Inc. 300 Pearl St., New York City Lanoline U. S. P., olive oil, ethyl chlorid, "Fixanal" prep- arations, litmus paper, membrane filtering apparatus, laboratory reagent chemicals, Doctor Kolthoff's buffer tablets.	530
Maquet, C., A. G. Heidelberg, Germany	102	Pfaunder Co., The Rochester, N. Y. Glass lined laundry chute and other glass lined equipment.	28
Marbleoid Co., The 225 W. 34th St., New York City Marbleoid flooring products, Tiletex flooring products.	15	Physicians and Hospitals Supply Co. 412 S. Sixth St., Minneapolis, Minn. Enamel furniture, metabolism apparatus, scialytic lamps, drugs, sutures, rubber goods.	111
Marvin Co., E. W. Troy, N. Y. Garments and supplies for nurses and hospital personnel.	118, 120	Physicians' Record Co. 161 W. Harrison St., Chicago Hospital records and filing devices, hospital publicity material.	519
Massillon Rubber Co., Inc. Massillon, Ohio Surgeons' rubber gloves, cigarette drainage tubing, exam- ination cots, obstetrical gloves, tissue finger cots and Kollman dilator covers.	11	Pick-Barth Co., Albert 208 W. Randolph St., Chicago Hospital furnishings and equipment.	417, 516
Medical Specialties Mfg. Co. 28 W. 58th St., New York City Doctor Abt's electric breast pump, the "Neuro-Myostat," Doctor Schomburg's operating light.	525	Postum Company, Inc. 250 Park Ave., New York City Exhibit of educational department—supplementary teaching materials—demonstration of Postum Company products, Postum, grape-nuts, Post's bran flakes, Post Toasties, minute tapioca, Walter Baker's cocoa and chocolate, Sanka coffee (decaffeinated), demonstration of Jell-O products.	200, 202
Meinecke & Co. 225 Varick St., New York City Rubber goods, enameled ware and surgical supplies.	201, 300		
Melrose Hospital Uniform Co. 119 W. 24th St., New York City Hospital clothing, rubber sheets and sheeting.	235		
Metropolitan Hospital Supply Co., Inc. 12 E. 12th St., New York City Hospital supplies.	415		

	Booth No.		Booth No.
Procter & Gamble Sixth and Main Sts., Cincinnati Soap and soap dispensers.	313	Spencer Lens Co. 33 W. 42nd St., New York City Microscopes, microtomes, haemometers, projectors.	625
Ravenna Products, Inc. 2908 Woolworth Bldg., New York City Ravenna rat powder, Ravenna roach powder.	31	Squibb & Sons, E. R. 80 Beekman St., New York City Biologicals, arsphenamins, insulin and chemicals.	220, 222
Read Machinery Co. York, Pa. Kitchen machines and bakery equipment.	23	Standard Apparel Co. 5604 Cedar Ave., Cleveland Nurses' capes, coats, knit goods.	113
Reynolds Electric Co. 2650 W. Congress St., Chicago Reco mixer and Reco peeler.	127	Standard Electric Time Co. 89 Logan St., Springfield, Mass. Doctor paging system, nurse hospital calling system, doctor "in and out" system, electric time clock system.	602, 603
Rhoads & Co. 107 N. 11th St., Philadelphia Hospital linens and textiles.	655, 657	Standard Gas Equipment Corp. 18 E. 41st St., New York City Vulcan gas ranges, broilers, toasters and bake ovens.	12, 14
Richey, Browne & Donald, Inc. 2101 Flushing Ave., Maspeth, N. Y. Browne steel windows, Browne windows made of bronze and aluminum alloy.	612	Standard Sanitary Mfg. Co. P. O. Box 1226, Pittsburgh Plumbing fixtures.	419, 421
Rider Co., P. L. 317 Main St., Worcester, Mass. Rubber goods, enamel ware, hospital glassware, monel metal, thermometers, artificial limbs.	619	Stanley Insulating Co. Great Barrington, Mass. Metal or unbreakable thermal containers.	502
Ritter Dental Mfg. Co., Inc. Rochester, N. Y. Complete equipment necessary for the establishment of dental clinics.	210, 212, 214	Stanley Supply Co. 118 E. 25th St., New York City Hospital supplies and equipment.	205, 207
Rolscreen Company Pella, Iowa Metal rolling window screens.	614	Stedman Products Co. South Braintree, Mass. Rubber tile flooring, rubber wainscoting, rubber bed bumpers, rubber desk tops, rubber door stops.	633, 635
Ross, Inc., Will 457 E. Water St., Milwaukee Hospital supplies, hospital and nurses' garments, door locking devices, hospital linen and silverware.	27	Stickley Bros. Co. Grand Rapids, Mich. Hospital furniture in wood.	608
Royal Easy Chair Corporation Sturgis, Mich. Reclining chairs for convalescents.	638	Stratford-Cookson Co. 4058 Haverford Ave., Philadelphia Anesthesia.	606
Sanitary Supply & Specialty Co. 244 W. 23rd St., New York City Paper specialties.	101	Studebaker Corporation of America South Bend, Ind. Ambulance.	48, 50
Sanymetal Products Co. 1705 Urbana Road, Cleveland Cubicle partitions, office partitions, toilet, shower and dressing room partitions.	432, 434	Thorner Bros. 135 Fifth Ave., New York City General hospital supplies and specialties.	1
Saunders Co., W. B. 7th and Locust Sts., Philadelphia Books.	323	Toledo Technical Appliance Co. 2226 Ashland Ave., Toledo, Ohio Anesthetic appliance, metabolic surgical pumps and piping.	522, 524
Scanlan-Morris Co. Madison, Wis. Sterilizers, operating room equipment and ward furniture.	424, 426	Trained Nurse & Hospital Review, The 468 Fourth Ave., New York City Publication.	505
Schellberg Mfg. Corp. 172 Chambers St., New York City Schellberg colonic therapy apparatus, tubes and books together with motion pictures.	510	Troy Laundry Machinery Co., Inc. East Moline, Ill. Troy Premier drying tumbler, Troy all monel metal Premier washer, Trojan extractor and two roll ironer.	37, 39, 126, 128
Schering & Glatz, Inc. Bloomfield, N. J. Autophan, tablets and powder, Anusol hemorrhoidal suppositories, Peralga, tablets and powder, Arcanol tablets, Gynodyne tablets, Ampoule products.	19	U. S. Slicing Machine Co. 612 N. Michigan Ave., Chicago	138
Schoedinger, F. O. 322 Mt. Vernon Ave., Columbus, Ohio Hospital furniture.	301, 400	Utica Steam and Mohawk Valley Cotton Mills Utica, N. Y. Utica and Mohawk wide sheeting, sheets and pillow cases.	532
Schwartz Sectional System Indianapolis, Ind. System for filing pharmacy and laboratory supplies.	649, 651	Vestal Chemical Co. 215 Pine St., St. Louis Sanitary supplies, surgical soaps, anti-septics, disinfectants, floor cleansers.	534
Scialytic Corporation of America 810 Atlantic Bldg., Philadelphia Scialytic shadowless operating lights.	116	Victor X-ray Corporation 2012 W. Jackson Blvd., Chicago X-ray equipment.	511, 513, 515, 624, 626
Seidel & Sons, Ad. 1245 Garfield Ave., Chicago Jelly maker, desserts and dry beverages.	653	Vitaglass Corporation 50 E. 42nd St., New York City Vitaglass.	401
Sexton & Co., John P. O. Box J S, Chicago Canned goods, preserves, pickles, teas, coffees and gelatin desserts.	310, 312	Wagner Manufacturing Co. Sidney, Ohio	42
Simmons Co., The 666 Lake Shore Drive, Chicago Beds and bedding, steel furniture.	640, 642, 644, 646	Waters-Genter Co. 213 N. Second St., Minneapolis, Minn. Electric toasters, waffle irons, food cabinets.	121
Smith Drum & Co. Allegheny Ave. below 5th St., Philadelphia Laundry equipment.	25	Welch Mfg. Co., W. M. 1516 Orleans St., Chicago. School and laboratory furniture, apparatus and supplies.	216
Sorenson Co., C. M. 444 Jackson Ave., Long Island, N. Y. Tankless air compressors.	230	Westinghouse Electric & Manufacturing Co. East Pittsburgh, Pa. Commercial cooking equipment and Micarta trays.	209, 211, 213
		Wiley-Wray Carbon Arc Co., The 1593 Central Parkway, Cincinnati Schwartz high intensity carbon arcs.	604, 605
		Williams & Co., C. D. 246 S. 11th St., Philadelphia Nurses' uniforms, clothing for staff, resident physicians and interns.	136

	Booth No.		Booth No.
Williams Pivot Sash Co. 1827 E. 37th St., Cleveland Reversible window equipment for double hung wood windows.	46	Shriners' Hospital for Crippled Children Albany, N. Y.	731, 732, 733, 734
Wilson Rubber Co. Canton, Ohio Rubber gloves.	208	United Hospital Fund Hospital Information and Service Bureau New York City	739
Yawman & Erbe Mfg. Co. Rochester, N. Y. Hospital filing systems and equipment.	431, 433	United States Public Health Service, Washington, D. C.	839, 840, 841, 842, 843
Zeiss, Inc., Carl 485 Fifth Ave., New York City Optical instruments and operating lamps.	311	United States Army, Medical Department Washington, D. C.	823-838
Zimmer Mfg. Co. Warsaw, Ind. Splints and appliances for treatment of fractures.	504	United States Veterans' Bureau Washington, D. C.	850, 851, 852, 853, 854

List of Educational Exhibitors at Atlantic City Convention

	Booth No.
American Association of Hospital Social Workers Chicago	721, 722
American College of Surgeons Chicago	723, 724, 725
American Dietetic Association Chicago	743
American Institute of Architects Washington, D. C.	800-822
American Library Association St. Paul, Minn.	747, 748
American Medical Association Chicago	711, 712, 713
American Occupational Therapy Association New York City	704, 705, 706, 707, 708
American Protestant Hospital Association Cincinnati	844
American Red Cross, The Washington, D. C.	745, 746
American Social Hygiene League New York City	728
American Society for the Control of Cancer, The New York City	719, 720
Committee on the Grading of Nursing Schools New York City	740, 741
Department of Health Chicago	847
Department of Health New York City	848, 849
Department of Pensions and National Health Ottawa, Canada	729, 730
Division of Preventable Diseases Minneapolis, Minn.	845, 846
Hospital Library and Service Bureau Chicago	749, 750, 751, 752, 753, 754
International Council of Nurses, The Geneva, Switzerland	742
National Child Welfare Association New York City	726, 727
National Hospital Day Committee of the American Hospital Association C. J. Cummings, Chairman Tacoma, Wash.	744
National League of Nursing Education New York City	714, 715
National Tuberculosis Association New York City	718
"Netherlands" Under the direction of Dr. W. H. Mansholt Groningen, Netherlands	736, 737, 738
New York State Department of Mental Hygiene Albany, N. Y.	700, 701, 702, 703
New York Tuberculosis and Health Association, Inc. New York City	709, 710
Reconstruction Hospital New York City	735

New York and Lying-In Hospitals Merge

Merger of the New York Hospital and the Lying-In Hospital, two of the oldest and most important institutions among the fifty-nine nonmunicipal hospitals comprising the United Hospital Fund, emphasizes the tremendous growth in hospital accommodations in New York City during the last century.

The New York Hospital was founded in 1791 and the Lying-In Hospital in 1799. For more than half a century the New York Hospital was the only general hospital in the city. Preceding its establishment there was not a single hospital bed available in the city for 300,000 persons.

To-day there are approximately 35,000 hospital beds, municipal, nonmunicipal and private, in New York City, or about 4 per cent of the hospital beds in the United States.

The New York Hospital and Lying-In Hospital and Cornell Medical College will become part of a unified enterprise for care of the sick, research and medical teaching with combined funds for buildings, equipment and endowment that are expected eventually to approximate \$60,000,000.

New Procedures Followed in Philadelphia Mental Clinic

Announcement is made of the cornerstone laying for an out-patient clinic at the 178-year-old Pennsylvania Hospital for Mental and Nervous Diseases, Philadelphia. The new clinic, according to Arthur V. Morton, president of the hospital, marks a departure from the usual procedure in treating cases of this kind.

Arrangements are made so that patients, while being treated, may remain at home or carry on with their usual occupations.

Children's Hospital Is Gift to Greensboro, N. C.

Mrs. Edward Benjamin, New Orleans, has announced the gift of the home of her late parents, Mr. and Mrs. Emanuel Sternberger, Greensboro, N. C., to the city of Greensboro for use as a children's hospital.

The palatial home, handsomely landscaped grounds, nurses' home at the rear and equipment for the hospital will represent an outlay of over \$150,000. In addition to this Mrs. Benjamin is endowing the hospital with a sufficient amount to partly maintain it in operation. The gift is made in memory of her father, mother and sister, all three of whom have died within the last few years.

Noted Occupational Therapists on Annual Program, June 17-19

THE program is completed and all is in readiness for the thirteenth annual meeting of the American Occupational Therapy Association in Atlantic City, N. J., June 17, 18 and 19. The program as planned will give all association members an opportunity to take part in the discussions. Celebrated occupational therapists from all parts of the country are numbered among the speakers. Dr. René Sand, technical counselor to the League of Red Cross Societies, Paris, France, is to give an address at the annual banquet on the evening of June 18.

Registration of delegates will take place Monday morning and the convention will be formally opened Monday afternoon with an address of welcome by William J. Ellis, commissioner, department of institutions and agencies for New Jersey. Dr. Joseph R. Morrow, president, New Jersey Hospital Association, will bring greetings to the occupational therapists to which Dr. C. Floyd Haviland, president, American Occupational Therapy Association, will respond. Doctor Haviland will also give the presidential address at this time. Following the report of the secretary-treasurer, Mrs. Eleanor Clarke Slagle, the report of the finance committee given by the chairman, Mrs. Frederick W. Rockwell, and the appointment of the committee on resolutions, a tea will be held honoring the presidents of the state and local occupational therapy associations.

Talk to Be Illustrated

Winifred Conrick, chief occupational therapist, James Whitcomb Riley Hospital for Children, Indianapolis, Ind., is to be the first speaker on the program for Tuesday morning, with an illustrated talk on occupational treatment for children at Riley Hospital. The discussion following Miss Conrick's talk will be led by Mrs. John A. MacDonald, occupational therapy chairman, Junior League, Indianapolis. Occupational therapy activities in Riley Hospital are maintained by the Junior League of Indianapolis.

Grace Bryant, director, occupational therapy, Zem Zem Hospital for Crippled Children, Erie, Pa., will tell of the occupational treatment for children at Zem Zem Hospital. The discussion will be led by Alice Dean, director, occupational therapy, Orthogenic School, Chicago. Dr. J. W. Hinton and Mary E. Morritt, director, occupational therapy, Bellevue Hospital, New York City, are each scheduled to speak on the use of occupational therapy in the treatment of joint fractures, and Major Harry D. Offutt, chief, occupational therapy and physiotherapy departments, Walter Reed General Hospital, Washington, D. C., is to have as his subject, "Occupational Therapy in a Military General Hospital." The discussion leader following this talk is Alberta Montgomery, supervisor, occupational therapy, Walter Reed General Hospital.

"Occupational Treatment in Nervous Diseases," is the subject of a paper to be given by Dr. Goldwyn Howland, president, Canadian Occupational Therapy Association, Toronto, Canada, at the opening of the Tuesday afternoon session. Dr. Horatio M. Pollock, director, statistical bureau, State of New York Department of Mental Hygiene, Albany, will speak on the need, value and general principles of occupational therapy statistics. "The Con-

tribution of Occupational Therapy to Child Guidance Work," is the subject of a paper to be given by Dr. Clarence A. Bonner, superintendent, Danvers State Hospital, Hathorne, Mass., and Marjorie B. Greene, dean, Boston School of Occupational Therapy, Boston, will lead the discussion following Doctor Bonner's speech. Dr. Henry I. Klopp, superintendent, Allentown State Hospital, Allentown, Pa., is to speak on "Occupational Treatment in Schizophrenia," and the discussion will be led by Gladys Carter, chief occupational therapist, Allentown State Hospital. A general discussion will follow.

The annual banquet will be held Tuesday evening with Dr. René Sand, technical counselor to the League of Red Cross Societies, as the speaker of the evening.

Leslie Wood, chairman, shops committee, Industrial Workshops, Rochester, N. Y., has the first place on the Wednesday morning program with a discourse on the subject, "The Industrial Curative Workshop and Its Importance to the Community." Illustrative cases will be presented by Elizabeth K. Wise, director, occupational therapy, and the discussion leader will be Gladys Pattee, director, occupational therapy, Mayo Clinic, Rochester, Minn.

Marjorie Taylor, advisory director, Junior League Curative Workshop, Milwaukee, will tell about the activities of the Junior League Curative Workshop, and moving pictures illustrating the work will be shown by Henrietta McNary, assistant occupational therapist. Dr. Mandell Shimberg, Syracuse, N. Y., will speak on "A Reconstruction Clinic," with illustrations by Marian Clark, director, occupational therapy. Martha R. Emig, occupational therapist, will tell of some experiences in a private occupational therapy clinic.

The closing session, Wednesday afternoon, will be given over to reports. Mrs. Carl H. Davis, Milwaukee, will give the report of the standing committee on teaching methods; T. B. Kidner, New York City, will give the report of the committee on national registration and Dr. William R. Dunton, Jr., Catonsville, Md., will give the report of the standing committee on publicity and publications. The report of the resolutions committee will also be given.

A business session, to which admission may be secured by membership card only, will follow, when plans for making the national registration scheme effective will be discussed. Election of officers for the coming year will bring the 1929 session to a close.

Cornerstone Is Laid for New Chicago Hospital

With the laying of the cornerstone, construction was begun on the new hospital of the Little Company of Mary, a nursing order of nuns, that is to take its place with other Chicago hospitals. Clergy from all parts of the archdiocese were in the crowd of 3,500 friends of the nuns who attended the cornerstone laying ceremonies. The first unit of the new hospital will be completed by Fall it is announced.

NEWS OF THE MONTH

Father Moulinier Withdrawn From Hospital Activities

ONE of the best balanced programs that has been heard at any meeting was presented at the fourteenth annual convention of the Catholic Hospital Association held May 6 to 10 at the Stevens Hotel, Chicago. The attendance at this meeting far exceeded that of any previous convention and the interest displayed by the Sisters Superior and the department heads in all phases of hospital administration was one of the factors that made the program excellent.

On the last afternoon the election of officers was held. Father Alphonse M. Schwitalla, S.J., dean of the St. Louis University School of Medicine, was reelected president. The other officers were as follows: first vice-president, Rev. Maurice Griffin, Cleveland; secretary and treasurer, Sister Mary Irene, St. Mary's Hospital, St. Louis; executive board, Sister Helen Jarrell, directress of nurses, St. Bernard's Hotel Dieu Hospital, Chicago; Sister Mary Rose, Mercy Hospital, Pittsburgh, Sister Mary Leonissa, St. Elizabeth's Hospital, Lafayette, Ind., Mother Alain, Grey Nunnery of Canada, Sister Mary Therese, Mercy Hospital, Chicago, and Mother Marie, St. Mary's Hospital, Green Bay, Wis.

Receives Gift From Association

At the opening meeting a resolution was offered and accepted making Father C. B. Moulinier, S.J., founder of the association and president until last year, a permanent honorary president. Father Moulinier, who is of the Order of Jesus, has been withdrawn from hospital work and assigned to other duties. A purse of \$3,000 was also raised by the association as a gift to Father Moulinier.

The convention opened on Monday morning with a Pontifical High Mass at the Holy Name Cathedral with the Rt. Rev. Edward F. Hoban, Bishop of Rockford, Ill., the celebrant. The sermon was given by Rev. J. P. Boland, diocesan director of hospitals, Buffalo, N. Y., and for many years one of the leading advisers of the Catholic Hospital Association.

At noon a luncheon was given to the delegates by the Hospital Exhibitors' Association when reports of the Catholic organization were received. An excellent balance was shown in the treasury of the association in the report of Ray Kneiff, executive secretary, who placed assets at more than \$53,000.

Monday afternoon was spent by the Sisters in visiting the exhibits which were in the basement of the hotel and which constituted one of the best shows ever presented. Indeed it was so good that superintendents of other than Catholic hospitals from Chicago, Illinois, Indiana and Ohio were present.

The first meeting was a general session at which Father Schwitalla presided. The general theme was "The Pa-

tient." The first paper was read by Father Schwitalla and was entitled "The Patient; Biological Considerations." Rev. Robert E. Lucey, director, Diocesan Charities, Los Angeles, then presented a paper entitled "The Patient; Sociological Considerations." The third paper was presented by Rev. John P. Boland and was entitled "The Patient; Ethical and Religious Considerations." The concluding paper of this session was by Dr. Louis D. Moorehead, dean of the Loyola University School of Medicine, and was entitled "The Patient; Medical Considerations."

The afternoon session was divided into two parts, one conducted by John A. McNamara, executive editor, THE MODERN HOSPITAL, and Sister Julia, business manager, John B. Murphy Memorial Hospital, Chicago. This session was devoted to practical hospital administration as it affects the cost to the patient. Those participating were Carl A. Erikson, architect, Chicago; Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago; Dr. Malcolm T. MacEachern, associate director, American College of Surgeons; L. C. Austin, superintendent, Mt. Sinai Hospital, Milwaukee; F. S. Sinex, Indiana Inspection Bureau, Indianapolis; Walter Krieger, engineer, Insurance Company of North America, and Matthew O. Foley, editor, *Hospital Management*. There was much discussion at this meeting and many comments upon the fine presentation of hospital administration problems by Sister Julia. The second session was conducted by Sister Mary Rose, Mercy Hospital, Pittsburgh, and Dr. William Henry Walsh.

Administrative Phases Discussed

Administrative phases of hospital work were discussed at the Wednesday morning session which was conducted by Father Boland. Dr. T. R. Ponton, superintendent, Illinois Masonic Hospital, Chicago, presented a paper on "The Hospital of To-day," and Dr. Hermann von W. Schulte, dean, Creighton University School of Medicine, Omaha, Neb., talked about the obligations of the hospital to the doctor. An excellent and instructive address was given by Rev. Joseph F. Higgins, regional director, Rocky Mountain States Catholic Hospital Association, Pueblo, Colo., on hospital advertising. Father Higgins proved to be a logical thinker and a good speaker. The last paper of the morning was given by Brother Julius of the Alexian Brothers Hospital, Chicago, and pertained to the engineering problems of a hospital. Brother Julius showed how money can be saved if proper attention is given to the direction and management of this department of the hospital.

Wednesday afternoon sessions were conducted by Anna E. Boller, director of dietetics, Central Free Dispensary, Rush Medical College, Chicago, and Sister M.

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Victor, dietitian, St. Mary's Hospital, Rochester, Minn. Four dietetic problems were discussed at this meeting by Dr. Donald P. Abbott, associate clinical professor of medicine, Rush Medical College, Sister Victor, Katherine M. Thoma, dietitian, Michael Reese Hospital, Chicago, and Ruth M. Cooley, dietitian, Jewish Hospital, St. Louis.

Another section was held under the leadership of Ruth Emerson, University of Chicago, Edith Baker, vice-president, American Association of Hospital Social Service Workers, and Irene Morris, supervisor of social service, St. Mary's Group of Hospitals, St. Louis University, St. Louis.

Thursday morning was given over to a discussion of "The Doctor, the Hospital and the Patient," with Dr. Fred C. Zapffe, secretary, Association of American Medical Colleges, Chicago, presiding. Medical problems of the hospital were discussed at this meeting.

Clinical Records Described

On Thursday afternoon one section discussed autopsies while another discussed clinical records. Both sessions drew capacity audiences and were most interesting.

Much of the Friday morning session, which was under the auspices of the Illinois State Conference of the Catholic Hospital Association, was given over to problems of nursing. The business session also consumed much of the morning's session.

A plan of reorganization was presented by Father Boland at this meeting and it was voted to refer this to the executive board for consideration and to pass upon it at the meeting to be held next year. Several resolutions were presented by the resolutions committee. Father Griffin presented a resolution asking that the association go on record against the increase of tariff on surgical instruments. This was passed and Father Schwitalla further urged each Sister to send a telegram to her congressman asking his support in opposing this bill. Father Lucey was appointed official delegate to Washington to oppose the bill.

Junior Service League Sponsors Orthopedic Clinic

Having raised the necessary funds to carry on the work of the recently opened orthopedic clinic at the Englewood Hospital, Englewood, N. J., the Englewood Junior Service League has agreed to supply the clinic aids needed to help the hospital staff conduct the work. These aids will take the place of paid workers who are ordinarily employed to assist the doctors and nurses in the clinic. Eleven patients were treated on the first day the clinic was opened. The most modern physiotherapy equipment, donated by friends of the hospital, is used in treating patients.

During March a group of fifteen members of the league, including the three present at the opening of the clinic, has been preparing for clinic work through a comprehensive course of study. This consisted of four lectures and two periods of observation in different clinics. The lectures were devoted to organization of clinics, responsibility

of volunteer aids in clinic work, the professional ethics governing the work, the social aspects of a clinic and clinic procedure, routine, records and accounts.

Veterans' Hospital Occupies New Buildings

The neuro-psychiatric hospital, Roxbury, Mass., leased by the Veterans' Bureau since 1922, has been closed following the transfer of 263 patients to the new hospital at Bedford, Mass.

The Bedford Hospital was recently completed for the Veterans' Bureau at a cost of approximately \$1,500,000. It consists of twenty buildings and at present has 350 beds. It was built to allow for a possible increase in beds to from 800 to 1,000.

The Bureau is replacing the leased hospital facilities with permanent fireproof buildings as rapidly as is compatible with good administration and as funds are available, according to the announcement.

Eye and Ear Hospital Opens in September

Opening of the new \$1,500,000 Brooklyn Eye and Ear Hospital, Brooklyn, N. Y., is scheduled for September, according to an announcement made by Henry Baker, superintendent.

More than \$1,000,000 has been raised for the hospital in a three-year campaign for funds, it is stated, and \$300,000 additional is being sought for the purchase of equipment.

The new building will accommodate 175 patients, not including those attending clinics, and will include ten operating rooms and a special operating room for the removal of tonsils and adenoids. A large room with a seating capacity of 600 persons is planned for clinics and a solarium will be placed on top of the building.

Bay Region Record Librarians Organize

An organization that will be known as the Association of Record Librarians of the Bay Region of California, was formed at a meeting of record librarians held at the Samuel Merritt Hospital, Oakland, recently. Alice G. Kirkland, record librarian, Samuel Merritt Hospital, was acting chairman.

Ten hospitals in San Francisco, Oakland and Berkeley were represented and the meeting was enthusiastic. The association will meet once a month at the different hospitals to discuss the problems that arise in the work of the record librarian and to promote the high standards and ideals of the Association of Record Librarians of North America. It is hoped that the local association will be the nucleus of a state organization.

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Endowment of Nursing Schools Urged at Minnesota Meeting

ROCHESTER, Minn., famous through its association with the name of Mayo, formed the setting for the annual convention of the Minnesota Hospital Association, which met at the Kahler Hotel in that city, May 10 and 11.

Between one and two hundred delegates gathered and enjoyed a splendid one-day program, planned by the energetic and progressive officers of the association. President Donald C. Smelzer, superintendent, Charles T. Miller Hospital, St. Paul, took the chair at both the morning and afternoon sessions and was highly successful in sustaining the interest of those present and eliciting discussion from the floor of the more important and practical topics that came up for discussion.

The report of the nominating committee was presented at the morning session by James McNee, superintendent, St. Luke's Hospital, Duluth, chairman of the committee, and balloting was carried on during the day. At the afternoon meeting the election of the following officers was announced: president, J. J. Drummond, manager, Worrell Hospital, Rochester; first vice-president, Harriet S. Hartry, superintendent, St. Barnabas Hospital, Minneapolis; second vice-president, Sister M. Julitta, superintendent, St. Raphael's Hospital, St. Cloud; third vice-president, Rev. W. Merzdorf, superintendent, St. Lucas Deaconess Hospital, Faribault; executive committee, Doctor Smelzer, Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, and Paul H. Fesler, superintendent, University Hospitals, Minneapolis.

After registration on Friday morning, President Smelzer opened the first general session. Invocation was by Rev. G. P. Sheridan, D.D., and following this J. J. Drummond welcomed the delegates. His address was responded to by Miss Rogers who said that the interest surrounding the Mayo Clinic made the holding of the convention in Rochester particularly advantageous to delegates.

Urges Grading of Nursing Schools

The first talk was given by Mary Gladwin, R.N., instructor of nurses, St. Mary's Hospital, Rochester, the topic being the education of the nurse and the grading of schools of nursing. Miss Gladwin made an eloquent plea for a sympathetic reception for the grading project as it is being carried forward by the Committee for the Grading of Nursing Schools. She reviewed the history of schools of nursing and showed that in establishing such schools it is seldom of the nurse and her education that we think but rather of the patient who must be nursed. Young women are not sought in order to be educated but in order to improve hospital conditions, she said. In other words, the nurse is but a means to an end. This, Miss Gladwin contends, is unfair to the nurse. Schools must be revolutionized and put on an entirely different basis—an educational basis. More care should be given to selection of applicants. A real school is

needed and students should pay for their instruction, she believes, and emphasis should be placed on the preparation of the supervisor for the task she has in hand, for what is needed, above all, is better teaching. Discussion of this paper was taken part in by Miss Rogers, Mr. Fesler, Dr. Ernest S. Mariette, superintendent, Glen Lake Sanatorium, Oak Terrace, and Rev. J. A. Bauernfeind, president of the American Protestant Hospital Association, all of whom warmly praised the exceptionally fine manner in which Miss Gladwin presented the case for the nurse while at the same time she gave her listeners the pleasure of hearing a speech that was clothed in beautiful English and had many graces.

Tells of Laboratory Needs

Dr. Bowman C. Crowell, associate director, American College of Surgeons, Chicago, was the next speaker and his subject was "The Laboratory, the Records and the X-Ray in the Small Hospital." Doctor Crowell pointed out that one or two weekly visits from a competent laboratory technician are sufficient for the laboratory need of the small hospital and that to send specimens of tissues by mail to a central diagnostic laboratory is also a good method for the small hospital to adopt. Thus one man can be made to serve many. Doctor Crowell then read the standards for clinical laboratories as adopted by the American College of Surgeons.

A paper on "The Administration of the Dietetic Department in the Hospital" was next presented by Edna Ferber, dietitian, St. Luke's Hospital, Duluth. Miss Ferber told of the development of the dietetic department of the hospital from the year 1921, which saw the beginning of dietetics, to the present time when the department has become accepted as an essential part of the hospital, responsible for 30 per cent of the hospital's expenditure. She enumerated in detail the duties of the dietitian, dealing in turn with her executive function by virtue of which she becomes in part the purchasing agent, and with her scientific or therapeutic function. Mary A. Foley, dietitian, Kahler Hospital, Rochester, discussed Miss Ferber's paper, as well as Mr. Fesler, Doctor Mariette and Joseph G. Norby, superintendent, Fairview Hospital, Minneapolis.

The last speaker at the morning session was Mr. Fesler, who gave an excellent talk on "The Organization of the Hospital," illustrated by a series of charts showing the duties that come under the different departments. In presenting the charts Mr. Fesler pointed out the merits of the various types of organization and explained how the systems were carried out.

Through the courtesy of the Kahler Corporation the members of the association were entertained at luncheon in the Kahler Hotel, at which time various announcements were made.

Committee reports were presented at the opening of the afternoon session. The report of the secretary-treasurer,

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Joseph G. Norby, superintendent, Fairview Hospital, Minneapolis, showed a satisfactory balance on hand and the officers are to be congratulated on the healthy state of the accounts.

At this session Doctor Smelzer delivered his presidential address, in which he gave a resumé of the association's work since the last convention, commented on new developments in the hospital field in general and suggested matters that might advantageously be studied by the association during the coming year.

The next speaker on the program was Perrie Jones, who gave a talk on libraries in state hospitals. Miss Jones told how the library work is carried on in the five state hospitals of Minnesota which she visits, three of which are hospitals for the mentally ill.

The outstanding feature of the afternoon session was Dr. W. A. O'Brien's talk on autopsies and how to secure them. Doctor O'Brien is associated with the department of pathology of the University of Minnesota, and his talk aroused keen interest. At the outset he stated that Rochester has the finest record in the United States for the number of autopsies done.

In defining an autopsy the speaker stated that it should be non-mutilating; it should be conducted in a respectful way; it should be clean; it should be done by a pathologist; it should be done in a suitable place, the autopsy room being preferably on the top floor. With regard to who should compose the audience when an autopsy is being performed, Doctor O'Brien said that there should be no restriction. It should be done before lay persons if they demand it; nurses should come; it should be done at a time and place suitable to all; a record should be made of the results and this should be a part of the hospital record and should be open to all who care to see it.

Autopsies Are Discussed

The reasons why autopsies should be performed were given as follows by the speaker: to determine whether the patient is alive or dead; to learn the cause of death; to make possible accurate records of the case; to discover if there were any hereditary disease; to uncover communicable disease; for the sake of justice to the deceased and to those left behind; to be of use in regard to insurance claims; to discover rare diseases; because autopsies are of teaching value to nurses and interns; for the purpose of scientific discoveries; for the disciplinary effect on the staff; to check therapy; for better embalming.

Doctor O'Brien's talk, which was illustrated by statistical charts, was discussed by Doctor Crowell, Miss Rogers, Mr. Fesler, Elizabeth McGregor, superintendent, Gillette State Hospital for Crippled Children, St. Paul, Doctor Mariette and others.

An open forum, presided over by Mr. McNee, concluded the afternoon session. The topics covered in this round table discussion were as follows: county allowance for hospital care for sick poor; how to get hospital trustees interested in hospital association meetings; room and ward prices; the problem of hospital visitors; hospital records; the value of decentralization of hospitals; standard lengths for hospital beds; should student nurses be permitted to assume the responsibility for nursing technique in major operations; what should be the ratio

of nurses to patients; the registration of clinical and pathological laboratory technicians.

In concluding the afternoon session Doctor Smelzer turned the meeting over to his successor, Mr. Drummond, who will conduct the affairs of the association during the coming year.

At the banquet held Friday evening in the Kahler Hotel the toastmaster was Dr. Charles H. Mayo, Mayo Foundation. The speakers were W. I. Nolan, lieutenant-governor of Minnesota, Dr. W. A. O'Brien and Dr. Bowman C. Crowell, all of whom gave interesting and entertaining talks. The proceedings were enlivened by instrumental music and a pleasant evening was spent.

Visits to surgical and medical clinics were planned for Saturday morning, and following a luncheon at the nurses' residence of St. Mary's Hospital, as guests of the Sisters of St. Francis, and a special carillon program, the delegates had the privilege of inspecting the new Mayo Clinic, an experience of marked interest and great educational value.

On a motion made by Miss Rogers it was decided to hold the next meeting of the association at St. Paul.

Minneapolis Clinic Purchases Eitel Hospital

The Nicollet Clinic, Minneapolis, has purchased Eitel Hospital, built in 1912 by the late Dr. George G. Eitel. The hospital is centrally located, with 330 feet frontage on one of the city's beautiful parks. A. G. Stasel, business manager, Nicollet Clinic, states that the purchase will nearly double the facilities of the clinic.

The erection of three additional stories to the present six-story structure will allow a capacity of 120 beds. All equipment is modern and includes complete chemical and x-ray laboratory facilities, with new high voltage deep therapy installation for the treatment of carcinoma.

Further plans are under discussion for the erection of a new eight to twelve-story clinic building on the property.

Addition to Red Wing Hospital Started

Construction of the \$70,000 addition to St. John's Hospital, Red Wing, Minn., has been started. A four-story brick building is to be built adjoining the south side of the main building and will provide wards, private rooms, kitchens, and sleeping quarters for employees.

Hillside Hospital Is Opened in Southern Oregon

Hillside Hospital, Klamath Falls, Ore., one of the most modern and complete hospitals in southern Oregon, was formally opened recently. Prior to receiving patients the hospital was opened for public inspection. Mrs. Ruby C. Lyle is superintendent.

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"Speechless" Banquet, Round Tables Attract 150 to New York Meeting

A MEETING made up entirely of round tables and a banquet that was practically "speechless" proved interesting enough to attract nearly 150 members of the Hospital Association of the State of New York to Rochester on May 16 and 17. Many subjects were discussed, and although the three sessions were long they were enjoyed.

An election of officers was held the last morning with the following result: president, Dr. C. W. Munger, Grasslands Hospital, Valhalla; first vice-president, Sheldon L. Butler, Long Island College Hospital, Brooklyn; second vice-president, Grace E. Allison, Samaritan Hospital, Troy; treasurer, P. Godfrey Savage, Niagara Falls Memorial Hospital, Niagara Falls; secretary, Boris Fingerhood, United Israel-Zion Hospital, Brooklyn; trustees, John R. Howard, New York Nursery and Child's Hospital, New York City, and Pearl Stout, Faxon Hospital, Utica.

The sudden death of M. Z. Westervelt, Staten Island Hospital, who was secretary of the association, was keenly felt by the members. Doctor Westervelt died May 11. A telegram was also read by Dr. John E. Daugherty, Jewish Hospital of Brooklyn, president of the association, from Charles F. Neergaard, representing the Carson C. Peck Memorial Hospital, Brooklyn, who was unable to be present because of an operation.

Out-Patient Department Discussed

Doctor Daugherty opened the first session with his presidential address which was followed by reports of committees. At eleven o'clock Mr. Fingerhood assumed the chair as round table conductor and introduced as the first speaker Dr. Walter S. Goodale, Buffalo City Hospital, who discussed the organization of an out-patient department. The out-patient work in Buffalo is more elaborate than in most cities and Doctor Goodale told how it had worked out in connection with his institution. Hester W. Browne, chief of social service work, Grasslands Hospital, Valhalla, then discussed social service work in connection with the out-patient department. Both the Buffalo City Hospital and Grasslands Hospital are large municipal and charity institutions with much out-patient work and while both speakers spoke from the standpoint of the large hospital, nearly all of their points applied equally well to the smaller hospital.

James U. Norris, Women's Hospital in the State of New York, New York City, conducted the first round table on the afternoon's program. Mr. Savage read the first paper on accounting and financial reports in which simplified and efficient systems of accounting were outlined. The next paper was by Dr. E. H. Lewinski Corwin, United Hospital Fund, New York City, and dealt with statistics and how to compile them. The United Hospital Fund keeps more complete hospital statistics than any other organization in the country and has a faculty for presenting them interestingly. Doctor Corwin urged

those present to keep an accurate check on every procedure and to use comparative statistics from time to time so that an accurate picture of the hospital's condition could always be presented.

The last paper on this round table was given by Matthew O. Foley, editor, *Hospital Management*, on publicity. Mr. Foley told of the results of good publicity to the hospital.

Dr. Christopher G. Parnall, Rochester General Hospital, presided at the second round table. In the absence of Father C. B. Moulinier, former president of the Catholic Hospital Association, Dr. Allan Craig, New York, and Doctor Corwin discussed the appointment of doctors to the hospital staff. Doctor Craig, who was formerly with the American College of Surgeons, explained the open and closed staffs and the methods of organization in various hospitals of the country.

Dr. J. Richard Kevin, Brooklyn, then spoke on the relation of the medical board to the hospital. He emphasized the importance of the medical work of the out-patient department and said that too often this department was considered as separate from the hospital when it should be considered a definite part of the institution.

Judge Callahan, president of the board of trustees, St. John's Hospital, Brooklyn, also spoke. Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, was the last speaker of the afternoon. He advocated more use of the intern on the premise that if the work of the intern shortened the stay of the ward patient it would follow that the same results would obtain if interns were used for patients in private rooms.

Banquet Is Enjoyable

In the evening an enjoyable banquet was served. Doctor Daugherty presided and Dr. Bert W. Caldwell, executive secretary, American Hospital Association, spoke on the aims of the hospital as they should be embodied in the "Hospital's Platform." Dr. John F. Bresnahan, St. Mark's Hospital, New York, presented "three problems" which proved to be three extremely funny instances that he had experienced in contact with patients. Doctor Bresnahan told the stories remarkably and proved to be the hit of the evening. The former commissioner of welfare of New York City, Bird S. Coler, was called upon and spoke briefly.

Mary E. Robinson, State League of Nursing Education, conducted the round table on Friday morning. Miss Allison discussed "Educational Standards for Schools of Nursing," Helen Wood, Strong Memorial Hospital, Rochester, discussed "How Properly to Combine Nurse Education With Service to the Sick" and Vidol Hudler, Jewish Hospital of Brooklyn, told of "Extra-Curricular Activities."

A luncheon was given to the delegates by Doctor Parnall at the Rochester General Hospital and hospital inspections occupied the afternoon.

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New Health Unit Opens in Los Angeles County

The fifth new health unit to be placed in operation in Los Angeles County, Calif., since 1924, was opened recently by the Los Angeles County Health Department, states the *Journal of the American Medical Association*.

Located at Belvedere Gardens, on the east side of the county, the new unit, housed in a \$96,000 building, will serve a population of about 175,000. The following bureaus of the central office operate in the new structure: medical and social service, maternal and child hygiene, sanitary inspections, public health nursing and tuberculosis division of the communicable disease bureau, branch of the county welfare bureau, emergency hospital and clinic for the indigent. It will serve also as headquarters for the training of all new employees of the entire county health department. The local medical profession comprises the voluntary staff of the health center, augmenting the resident staff of the physician in charge and his assistants. There are laboratories, roentgen ray, physical therapy and operating rooms, wards with a total of six beds, an auditorium and administrative offices.

The health units have been constructed under a plan adopted in 1924 which decentralizes the county health department and brings its facilities to outlying districts of Los Angeles. The department functions in an area of about 4,000 square miles in which there are thirty-one incorporated cities. Dr. John L. Pomeroy is the county health officer.

Passavant Hospital Formally Opened

The new \$1,900,000 quarters of Passavant Hospital on the McKinlock campus of Northwestern University, Chicago, were opened formally May 21 with a reception for the public.

More than 4,000 persons inspected the handsome new structure, which embodies the latest ideas in design, decoration and equipment. The interior is notable in that the traditional cold white of most hospitals is entirely lacking. In its place are found soft greens, yellows and pinks in all rooms and furnishings.

The bed capacity of the hospital is 325 although it will house only 217 patients until a home for the nurses, now quartered in the new building, is provided.

Negro Nurses Are Graduated From New York School

Forty-three young Negro women received diplomas at the twenty-eighth commencement program at the Lincoln School for Nurses, New York City, May 15. The exercises were held in the auditorium of the new school building, formal dedication of which will take place June 6.

Dr. Robert R. Moton, principal of Tuskegee Institute, Tuskegee, Ala., gave the commencement address and Dr. William Schroeder, Jr., commissioner of hospitals, New York City, also spoke.

The Lincoln School for Nurses is the largest institution

in the country devoted to the training of Negro nurses. Its students take the examinations of the New York State Board of Regents and receive the degree of registered nurse. Beside supplying all the nursing service for Lincoln Hospital, New York City, the school sends its graduates to positions throughout the United States.

Nurses Home Annex Will Be Erected Soon

Erection of a six-story addition to the present six and seven-story nurses' home of the Michael Reese Hospital, Chicago, has been announced. The annex will occupy a site adjoining the present building on the north and will cost, exclusive of the ground value, \$500,000. Quarters for 200 nurses and fifty interns will be provided.

Eye Hospital Treats Many Patients in Half Century

A total of 547,005 patients, as many persons as are to be found in a city as large as Buffalo, Milwaukee or Washington, or a state as large as Idaho or New Hampshire, have been treated in the Herman Knapp Memorial Eye Hospital, one of the United Hospital Fund group of institutions since its establishment fifty-nine years ago, according to its annual report made public recently.

During the past year the hospital treated 11,746 patients, of whom 823 were in the hospital proper and 10,923 in the out-patient department. More than 50 per cent of the total hospital days of care were given free to needy patients, the records showing 6,091 free days out of 12,269. No applicant is ever refused at the hospital because of inability to pay, the report states. The clinic draws its patients not only from the immediate neighborhood of the institution, but from all districts of Greater New York and not infrequently from neighboring states.

The institution, which was formerly known as the New York Ophthalmic and Aural Institute, in East Twelfth Street, is now located at Fifty-seventh Street and Tenth Avenue.

Connecticut Hospital Association Holds Spring Meeting

The spring meeting of the Connecticut Hospital Association was held May 15 at the Lawrence Memorial Hospital, New London.

Two important papers were read. In the morning Dr. Henry M. Pollock, superintendent, Homeopathic Hospital, Boston, presented a paper on "The Fixing of Hospital Charges and Collecting," and in the afternoon Annie W. Goodrich, dean, Yale School of Nursing, read a paper on "A Preclinical Course for Preliminary Students."

A short business session opened the meeting and members of the association were entertained at luncheon by Doctor Pollock.

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Program Complete for Children's Hospital Association Meeting

Administrators of children's hospitals in this country are to hear about child welfare work in Europe at the annual meeting of the Children's Hospital Association of America in Atlantic City, N. J., June 20. Dr. René Sand, president, International Hospital Congress, is to deliver an address on "Preparation and Orientation of Child Welfare Work in Europe," at the morning session, following a message of greeting to the Children's Hospital Association from the American Hospital Association brought by its president, Dr. Louis H. Burlingham.

"The Children's Hospital and Child Welfare" is the subject Grace Abbott, chief, Children's Bureau, Washington, D. C., is scheduled to discuss at the morning session. She will be followed on the program by Dr. A. Graeme Mitchell, chief of staff, Children's Hospital, Cincinnati, who will speak on "The Children's Hospital in Its Relationship to the Child Health Program of the Community."

At the afternoon session, Nell Clausen, Milwaukee Children's Hospital, Milwaukee, is to speak on "General and Special Diets in a Children's Hospital." Dr. J. Claxton Gittings, medical director, the Children's Hospital, Philadelphia, will speak on the subject, "How Can a Children's Hospital Obtain the Best Working Medical Staff?" Management of surgery in a children's hospital will be discussed by Dr. Stanley J. Seeger, Milwaukee Children's Hospital, Milwaukee, the convalescent hospital for children by Margaret Rogers, superintendent, Children's Hospital of Michigan, Detroit, and the hospital care of crippled children by Miss Byrd Boehringer, superintendent, Shriners' Hospital for Crippled Children, Greenville, S. C.

Hospital Social Workers Complete Plans for Annual Meeting

The American Association of Hospital Social Workers will meet in Atlantic City, June 17 to 21, the dates of the meeting of the American Hospital Association.

A joint session with the social service section, American Hospital Association, will open the meeting. Subjects under discussion will be "Functions of Hospital Social Service" and "Should Social Work in Hospitals Be Confined to Free or Part-Pay Patients?" Papers will be read by Mary K. Taylor, of the social service staff, Presbyterian Hospital, New York City, and Ora Lewis, Massachusetts General Hospital, Boston. Joint sessions will also be held with the teaching section, the out-patient section and the small hospital section.

Three group discussions on the subjects, "The Hospital's Responsibility for Giving Medical Data to Qualified Persons and Agencies," "Statistical Recording in Medical Social Work" and "The Contribution of Psychiatric Social Studies to Medical Diagnosis and Treatment," will be given by qualified persons in the field of medical social work.

Henri-Ette Kirch, director of social work, Graduate Hospital of the University of Pennsylvania, Philadelphia, will be in charge of the meetings. Social activities will include a dinner and a tea.

Georgia Hospital Association Has Splendid First Meeting

The Georgia Hospital Association met in first annual session in Macon, May 7. Although organized only last February, which allowed but little time to work up a membership and to prepare a program, the attendance was splendid and the papers and discussions were interesting and helpful. The three round table sessions on administrative and nursing problems were informal and practical, with all persons present taking part in the discussion.

A number of interesting papers were read. Dr. C. S. Lentz, superintendent, University Hospital, Augusta, gave a paper on needed hospital legislation in the state and Jane Van De Vrede, secretary, Board of Examiners of Nurses for Georgia, presented a paper on "The Future of Small Schools of Nursing in Georgia." Provision was made for definite committee work on legislative and other problems throughout the year. Dr. Bert W. Caldwell, executive secretary, American Hospital Association, Chicago, was present and gave a helpful talk on hospital service. He also conducted one of the round table discussions.

Dr. C. S. Lentz was elected president for the coming year. Annie Bess Feebeck, superintendent of nurses, Grady Hospital, Atlanta, was elected first vice-president. Dr. Albert S. Saunders, superintendent, Little-Griffin Hospital, Valdosta, was elected second vice-president. J. B. Franklin, superintendent, Georgia Baptist Hospital, Atlanta, was elected secretary-treasurer. The board of trustees consists of: Dr. C. S. Lentz, president; J. B. Franklin, secretary-treasurer; Dr. James L. Bevans, John D. Archbold Memorial Hospital, Thomasville; Dr. J. K. Quattlebaum, Savannah; Dr. Grady N. Coker, Coker's Hospital, Canton; Dr. Russell H. Oppenheimer, Wesley Memorial Hospital, Emory University and Dr. C. H. Richardson, Jr., Macon.

Educational Exhibit to Feature Nursing League Convention

Coincident with the annual meeting of the American Hospital Association, the National League of Nursing Education will hold its thirty-fifth annual convention at Atlantic City, June 17-21. One of the interesting and welcome features of the convention will be a joint meeting with the American Hospital Association on the evening of June 18 in the assembly hall at Convention Hall. The topic of the evening will be "Nursing Education."

An attraction of this year's convention of the National League of Nursing Education will be an educational exhibit. The exhibit will be of special value to all who are interested in nursing education.

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The main topics of the program and the speakers are: "Principles of Administration," Colonel Leonard Ayres; "Principles and Practice of Waste Elimination," Mrs. L. Gilbreth; "Mental Hygiene Applied to Personal Relationships," Dr. Esther Richards; "Interprofessional Relations," Mrs. Chase Going Woodhouse, chairman, Institute of Women's Professional Relations. A round table on "A Study of Health in Schools of Nursing" will be conducted by Florence W. Wilson. A round table will also be held on "Postgraduate Courses." Other topics to be discussed include "Personnel Management," "Staff Education" and "Correlation of Theory and Practice."

Hospital Service Conference to Operate Bureau

The American Conference on Hospital Service, with the full approval of its board of trustees and delegates, has made an agreement whereby the American Hospital Association will maintain and administer the Hospital Library and Service Bureau on and after June 30, 1929.

Donelda R. Hamlin, director of the Hospital Library and Service Bureau since its establishment, has presented her resignation to take effect June 25, 1929.

Protestant Hospital Group Will Hold Exhibit

Photographs and statistics are being collected by the American Protestant Hospital Association for an exhibit to be shown at the American Hospital Association convention at Atlantic City, June 17 to 21. The materials submitted will be shown in Booth 844.

John H. Olsen, until recently managing director, Bushwick Hospital, Brooklyn, N. Y., who is in charge of the exhibit, asks that Protestant hospitals send the following information to him at his home address, P. O. Box 86, Eltingville, Staten Island, N. Y.:

Name of hospital, denomination, value of buildings and grounds, yearly expense, cost per day, number of patients in 1928, number of hospital days, number of free or part-pay days and value, number of newborn, total number of nurses, number of student nurses, number of graduate nurses, number of deaconesses, number of ambulance calls, donations in 1928 and total endowments.

Annual Convention of I. C. G. N. Announced for July

The fifth annual convention of the I. C. G. N. will be held at Montreal, Canada, on July 5, 6 and 7, immediately preceding the convention of the International Council of Nurses. Convention headquarters will be at the Mount Royal Hotel, where all meetings and sessions will be held.

The transportation committee has arranged three separate itineraries in connection with the convention. No. 1

covers transportation to Montreal and return; No. 2 covers transportation to Montreal and return with an extension trip down the St. Lawrence River to Quebec and the Shrine of St. Anne de Beaupre; No. 3 covers transportation to Montreal, with return route, after visiting Quebec, via Lake George, the Hudson River, New York, Philadelphia, Atlantic City and Washington. There will be stop-overs of two days in New York, one day at Atlantic City and three days in Washington.

Information as to rates, reservations, transportation details and folders will be gladly supplied on request to the International Headquarters of the I. C. G. N., Suite 142, Auditorium Hotel, 430 South Michigan Avenue, Chicago.

For nurses who cannot conveniently board the special train at Chicago or who wish to make the trip to Montreal and return by another route, ample room reservations have been made at the Mount Royal Hotel to accommodate all who may come as guests or delegates to the convention. Rates will be quoted at headquarters.

Coming Meetings

American Association of Hospital Social Workers.

President, Gertrude L. Farmer, Boston City Hospital, Boston, Mass.

Secretary, Helen Beckley, 18 East Division Street, Chicago.

Next meeting, Atlantic City, N. J., June 17-21.

American Hospital Association.

President, Dr. L. H. Burlingham, Barnes Hospital, St. Louis.

Secretary, Dr. B. W. Caldwell, 18 East Division Street, Chicago.

Next meeting, Atlantic City, June 17-21.

American Medical Association.

President, Dr. William S. Thayer, Johns Hopkins Medical School, Baltimore, Md.

Secretary, Dr. Olin West, 535 North Dearborn St., Chicago.

Next meeting, Portland, Ore., July 8-12.

American Occupational Therapy Association.

President, Dr. C. Floyd Haviland, Manhattan State Hospital, Ward's Island, N. Y.

Secretary-treasurer, Eleanor Clarke Slagle, 175 Fifth Ave., New York City.

Next meeting, Atlantic City, N. J., June 17, 18, 19.

American Protestant Hospital Association.

President, Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago.

Secretary, Dr. Frank C. English, Hyde Park, Station O, Cincinnati.

Next meeting, Atlantic City, June 14-17.

Children's Hospital Association of America.

President, Dr. Howard Childs Carpenter, Philadelphia.

Secretary-treasurer, Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee.

Next meeting, Atlantic City, N. J., June 20.

International Catholic Guild of Nurses.

Next meeting, Montreal, July 5-6.

International Council of Nurses.

President, Nina D. Gage, 370 Seventh Ave., New York City.

Secretary, Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

Next meeting, Montreal, July 8-13.

International Hospital Congress.

President, Dr. René Sand, 2 Avenue Velasquez, Paris VIII, France.

Secretary, Dr. E. H. Lewinski Corwin, 2 East 103rd St., New York City.

Next Meeting, Atlantic City, N. J., June 13, 14, 15.

National League of Nursing Education.

President, Elizabeth C. Burgess, Teachers College, Columbia University, New York City.

Secretary, Nina D. Gage, 370 Seventh Ave., New York City.

Next meeting, Atlantic City, N. J., June 17-21.

New Jersey Hospital Association.

President, Dr. Joseph E. Morrow, Bergen County Hospital, Ridgewood.

Executive Secretary, W. Crane Lyon, 201 Lyons Ave., Newark.

Next meeting, October 4-5.

Personals

DR. DOUGLAS SYMMERS has been appointed general director of laboratories in the twenty-six hospitals in New York City, which are under the direction of the commissioner of hospitals, Dr. WILLIAM SCHROEDER, JR.

LAURA E. CLAUSEN is the new superintendent of the Memorial Hospital of Laramie County, Cheyenne, Wyo., succeeding CORINNE B. HENDERSON.

LAURA E. HENRY has accepted the appointment as superintendent of the Morristown General Hospital, Morristown, Tenn. The position has been held by JANE A. MILLER since the death last December of Orleana Painter.

SISTER M. AGATHA has been appointed to succeed SISTER MARY AIDAN as superintendent of Holy Rosary Hospital, Miles City, Mont.

RUBY F. GAINES is the newly appointed superintendent of Detroit Hospital, Detroit Lakes, Minn.

DR. GLENN J. SMITH, of Amite, La., recently was elected superintendent of the East Louisiana State Hospital for Insane, at Jackson. He succeeds Dr. T. J. PERKINS.

MABEL A. BRINGGOLD, R.N., has recently been appointed superintendent of Westlake Hospital, Melrose Park, Ill., where she will occupy the vacancy left by S. BESSIE BARNES, resigned.

MISS A. C. MACKLER has accepted the superintendency of Rogers Park Hospital, Chicago, following the resignation of JOSEPH PURVIS.

MRS. AGNES R. GAY has resigned her position as superintendent of Hope Haven Sanatorium, Jacksonville, Fla., and the appointment has been given to SUSAN M. FIELDS.

MARIE TALCOTT is the new superintendent at Sterling Hospital, Sterling, Colo., succeeding ETHEL W. DOWNING, resigned.

EVELYN WHITMER has been appointed superintendent of Drexler Hall, the children's hospital at Redwood City, Calif., succeeding ISABELLE W. GREGORY.

DR. E. H. CROSS has accepted the appointment as superintendent of Etowah County Tuberculosis Camp, Alabama City, Ala., to fill the vacancy caused by the resignation of I. RUTH STRINE.

J. Z. KERR, until recently superintendent, Ohio Valley Hospital, Steubenville, Ohio, has accepted the superintendency of the Fort Hamilton Hospital, Hamilton, Ohio, to be formally opened this Spring.

EARL F. MITCHELL, assistant superintendent, Binghamton City Hospital, Binghamton, N. Y., became superintendent, Oil City Hospital, Oil City, Pa., May 1. C. HERBERT JONES, Niagara Falls Memorial Hospital, Niagara Falls, N. Y., succeeds Mr. MITCHELL.

CHARLOTTE L. KERANS, R.N., has been named superintendent of the Findlay Hospital, Findlay, Ohio, succeeding MARY MARGERUM, resigned. Prior to her going to Findlay, Miss KERANS was superintendent, Geo. B. Wright Memorial Hospital, Fergus Falls, Minn.

DR. WILLIAM C. JENSEN formerly superintendent, Westmount Sanatorium, Glens Falls, N. Y., has resigned that position to accept a similar appointment at Oneida County Tuberculosis Sanatorium.

HAZEL B. PRESSER, superintendent, Howard County Hospital, Kokomo, Ind., has resigned.

MINNA E. SANDS, superintendent of nurses, Toledo Hospital, Toledo, Ohio, for the last thirteen years, has resigned. Her resignation becomes effective June 1.

DR. EARLE H. COON, assistant superintendent, State Hospital No. 3, Nevada, Mo., has accepted the appointment as superintendent to succeed Dr. JAMES H. PARKER.

DR. THOMAS K. GRUBER, superintendent of the Detroit Receiving Hospital, Detroit, Mich., since 1921, has been appointed medical superintendent of the Eloise Hospital and the Eloise Infirmary, Eloise, Mich., to fill the vacancy caused by the sudden death of Dr. JOSEPH E. BENNETT.

N. JOSEPHINE CASS, Providence, R. I., has been named superintendent of Plunkett Memorial Hospital, Adams, Mass. She succeeds LILLIAN FRASER, now serving as treasurer and general manager of Fenway Hospital, Boston.

JOHN H. OLSEN resigned the superintendency of Bushwick Hospital, Brooklyn, N. Y., leaving the institution May 15.

DR. ROY MORGAN has become superintendent of the Westfield State Sanatorium, Westfield, Mass., succeeding Dr. HENRY D. CHADWICK, who resigned to become director of tuberculosis work in Detroit, Mich. Doctor MORGAN was assistant superintendent under Doctor CHADWICK for nineteen years.

GRACE B. BEATTIE, superintendent of the Johnson Memorial Hospital, Somerville, Mass., for five years, resigned, March 1, in order to enjoy a period of rest and travel.

CHARLOTTE LANDT has accepted the superintendency of Sherman Hospital, Elgin, Ill. Miss LANDT has been superintendent of nurses at Lutheran Memorial Hospital, Chicago.

DR. ROBERT LINCOLN MURDY, one of South Dakota's best known surgeons, died April 30 at Lincoln Hospital, Aberdeen, S. D., from an infection sustained while operating on a patient. Doctor MURDY was a charter member of the American College of Surgeons and past president of the South Dakota State Medical Association. He was instrumental in founding several hospitals and clinics in Aberdeen.

DR. CHARLES B. BACON, medical superintendent, New York City Hospital, Welfare Island, has exchanged posts with Dr. MORTIMER D. JONES, medical superintendent, Kings County Hospital, Brooklyn, N. Y., and in taking over his new duties returns to the institution where he began his medical career as an intern thirty-one years ago.

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News of the Month

Michigan Hospitals Seek Law on Auto Accident Cases

TWO important questions of legislation were brought up for discussion at the annual meeting of the Michigan Hospital Association held at the Battle Creek Sanitarium, Battle Creek, April 25 and 26.

It was decided to instruct the executive committee to devise means of interesting the state legislature in the formulation of laws that will protect the hospitals of the state against losses occurring as the result of the non-payment of bills by victims of automobile accident cases. This is the first state to take decisive steps toward curbing by law the amount of money that is each year lost by those who receive treatment for injuries and who do not pay.

Another resolution adopted by the association was in the form of a protest against any legislation that would make high-school graduation compulsory for women entering the nursing profession. At the present time the state requirement is two years, although most of the training schools select high-school graduates only. However, it was thought that higher requirements by law would make it increasingly difficult to secure students.

Excellent Program Presented

The meeting of the association this year proved to be of a very interesting character first because it was held amid unique hospital surroundings and under the auspices of Dr. John Harvey Kellogg and Dr. Charles E. Stewart, assistant director of the sanitarium and president of the Michigan association, and second because of the unusually excellent program that was presented.

Doctor Stewart called the meeting to order on Thursday morning and then turned it over to Mary M. Harrington, dietitian, University of Michigan Hospital, Ann Arbor. The first session was held in conjunction with the meeting of the Southeastern Michigan Dietetic Association and the first paper was read by Dr. Helen Mitchell, Battle Creek Sanitarium, on "Recent Advances in Nutritional Research." Doctor Mitchell has done outstanding work in dietetic research and she presented many interesting facts regarding the various phases of studies that have been made.

S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, gave the second paper on "The Value of a Dietitian in the Out-Patient Department," in which he told of the work that was being done at Grand Rapids and other places where diets were a part of the regular out-patient department program.

An interesting and instructive talk was given by Margaret Brown who has charge of the cafeteria at the Statler Hotel, Detroit. Miss Brown told of the many duties that fell upon the dietitian in a hotel and weighed the differences with hospital work. She told of the personnel problem, the food buying and serving problem and the work that the Statler is doing in promoting special diets among its patrons.

A trip through the Battle Creek Sanitarium was en-

joyed on Thursday afternoon, ending in the chapel where Doctor Kellogg read an excellent paper on physical therapy work and its place in general hospitals. Some time was given to the discussion of the paper by superintendents of general hospitals who were present.

In the evening at the sanitarium the members of the association, the members of the dietetic association and the members of the sanitarium staff enjoyed a banquet at which time Dr. Harley A. Haynes, director, University Hospital No. 2, Ann Arbor, acted as toastmaster. Doctor Haynes introduced as the speaker of the evening, Prof. W. D. Henderson of the University of Michigan. Doctor Henderson spoke interestingly on many topics, laying stress on Einstein's theory of relativity, the effect of automatic machinery upon civilization and the trend of modern mankind.

On Friday morning Mr. Davidson read an unusually interesting paper on uncollectible accounts due to automobile accidents in which he presented some convincing figures as to the losses through these cases. It was at this point that the resolution was passed asking for legislative study of the problem.

The second paper presented was by Dr. Donald M. Morrill, director, Blodgett Memorial Hospital, Grand Rapids, in which he asked that hospital superintendents give study to the problem of criticism. He stated that while the hospitals were generally criticized by those people who were not qualified to criticize, seldom had hospital people arisen to answer these unjust attacks. He gave credit so far to only two people who had defended the hospitals, Dr. Michael M. Davis, director of medical services, Julius Rosenwald Fund, Chicago, and John A. McNamara, executive editor, THE MODERN HOSPITAL.

Explains Collection Methods

Alfred E. Judd, Maple Street Hospital, Battle Creek, spoke upon means of collecting uncollectible accounts and the use of credit bureaus in the collection of dormant bills. Mr. Judd told of the success he had had with these agencies of collection and urged the members to get in touch with their local credit bureaus for a similar service.

One of the most instructive papers ever heard at any hospital meeting was given by Dr. R. L. Kahn, director of laboratories, University Hospital No. 2, Ann Arbor. Doctor Kahn is internationally known as the originator of the Kahn Test which is receiving wide acceptance in all parts of the world in the detection of syphilis. Doctor Kahn described the three types of laboratories at the university hospital and told of the detailed workings of each.

The last paper at the morning session was given by Florence Babcock, record librarian, University Hospital No. 2, and was entitled, "Records, an Indicator to Hospital Efficiency." She told of the manner in which hospital records are kept, how histories are obtained and how staff members are made interested in the records. Her paper was much discussed by many of those present.

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News of the Month

The first paper at the Friday afternoon session was given by Dr. N. P. Colwell, secretary, Council for Medical Education and Hospitals, American Medical Association. Doctor Colwell outlined the requirements hospitals must conform to in order to train interns. He described the situation as it is at the present time regarding medical training and urged those present to get the staff more interested in the training of the young doctors.

Closer cooperation between hospitals and newspapers was urged by John A. McNamara, executive editor, *THE MODERN HOSPITAL*, in the second speech of the afternoon. Mr. McNamara also spoke upon public relations in all of its branches.

Dr. M. T. MacEachern, associate director, American College of Surgeons, was the third speaker. He told of the work that was being done in the periodic health examinations and of the benefits to the public that could be derived if hospitals would go more thoroughly into this work. He described the health inventories that have already been established.

Matthew O. Foley, editor, *Hospital Management*, was the fourth speaker and took as his topic ethical advertising by hospitals. Mr. Foley stressed the point of better cooperation between hospitals and the public.

The last speaker was Lyda Anderson, registrar, Nurses Official Registry, Detroit, who talked about community nursing programs.

Dr. Donald M. Morrill was elected president for the coming year; Mr. Davidson was elected first vice-president; O. C. Seelye, trustee, Highland Park General Hospital, Detroit, was elected second vice-president; Mrs. E. J. Ford, director, North End Community Clinic, Detroit, was elected third vice-president; Robert G. Greve, assistant director, University Hospital No. 2, Ann Arbor, was elected secretary, and Amy Beers, superintendent, Hackley Hospital, Muskegon, was reelected treasurer. Doctor Stewart and Dr. Warren L. Babcock, director, Grace Hospital, Detroit, were reelected trustees.

Radium Centers in London Hospitals Made Possible by \$250,000 Gift

Radium centers among London hospitals are to be made possible under the recent gift of Sir Otto Beit to King Edward's Hospital Fund. The gift to purchase radium amounts to approximately \$250,000.

A limited number of hospitals will be supplied with a quantity of radium sufficient to enable them to function as radium centers. This means that not only will they be able to treat their own patients with radium but will also be available for a supply of radium emanation to other hospitals. The hospitals that have greater need for radium than others will be given preference in the allocation of the radium. Such hospitals will include hospitals treating diseases of women and those treating diseases of the throat.

Three teaching hospitals in London at present have quantities of radium sufficient to provide radium emanation, and these will not share in the King's fund. Radium is to be supplied to another hospital which, together with

the amount it now has on hand, will enable it to function also as a radium center. After the allocation of the King's fund radium it is expected that all of the teaching hospitals in London will have radium enough to fulfill some, if not all, of their needs. Allocation will also be made to some of the general hospitals without schools and to some of the special hospitals, attention having been given to their special services in regard to the nature of the diseases treated by them.

The radium will be on loan to the individual hospital for a year and subject after that to withdrawal on a month's notice. It is to be available for all patients, both ordinary and pay-bed and is not to be removed beyond the hospital premises without the written authority of the King's fund.

To Open New Psychopathic Building at Grasslands Hospital Soon

With the opening of the new eighty-bed psychopathic building of Grasslands Hospital, Valhalla, N. Y., an acute situation in Grasslands will be relieved through the releasing of valuable bed space for tuberculous patients.

The removal of all mental cases to the new building also will make room for extension of the preventorium work and the treatment of protracted or chronic types of illness.

The new structure is an unusual type of building, modernly and adequately equipped to meet the many problems that will confront its medical and nursing staff. Every precaution has been taken, not only for the proper treatment of patients for observation and care, but for their personal safety. Facilities for the segregation of different types of cases are said to be excellent.

Apparatus for the administration of various forms of physiotherapy treatment, such as continuous baths, has been installed.

The preventive work of the new hospital will be extended by out-patient clinics, to be conducted by the medical staff at the hospital or at convenient parts of Westchester County. The clinics will serve patients who do not need hospital care and they also will be helpful in locating cases of mental disease at an early date when much can be done to avert and modify the later stages of the disease.

Hospital Law Handbook Is Now Available at Reduced Price

Last summer a review of the Michigan Handbook of Hospital Law, published by the Michigan Hospital Association, appeared in *THE MODERN HOSPITAL*. At that time these books were being sold at \$2 per copy, which was practically the cost of publication.

A fair supply of these books is still on hand, according to Robert G. Greve, secretary of the association and assistant director, University Hospital, Ann Arbor, Mich., and the association will be glad to dispose of them at \$1 per copy. "We would rather have the books in service than keep them on our shelves," Mr. Greve says.



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News of the Month

Chicago Chapter of Catholic Nurses Holds Banquet

The third annual banquet of the Chicago Chapter of the International Catholic Guild of Nurses, was held at the Palmer House, May 7, with an attendance far exceeding the expectations of those who had charge of arrangements. The grand ballroom was filled to capacity with Catholic nurses from the various hospitals of Chicago, and a most interesting program was presented.

Judge Francis B. Allegretti was introduced as toastmaster by the president of the Chicago Chapter, Rosemary Sweinhart. Rev. John P. Boland, diocesan director of hospitals of the Buffalo Diocese, gave the invocation, and following the dinner interesting addresses were given by Rev. Frederick Seidenburg, dean of the school of sociology, Loyola University, Dr. E. T. Olsen, chairman of the legislative committee, Mrs. Nan H. Ewing, directress of nurses, Ravenswood Hospital, Lyda O'Shea, president of the International Catholic Guild of Nurses and Rev. Edward F. Garesché, general spiritual director of the International Catholic Guild of Nurses.

Interspersed in the program were vocal selections given by Teenie O'Shea, Leonard J. Huber and Miss Cusac.

First Issue of New Nursing Magazine Is Published

The first issue of the *Courier of the I. C. G. N.*, the official organ of the International Catholic Guild of Nurses, has just come from the press. The matter is interesting, well balanced and varied in content.

The *Courier* is to be, as its name implies, a messenger serving to keep the members of the I. C. G. N. in touch with one another and will carry the message of the organization far and wide. It will, of course, work also for the steady advancement of the entire nursing profession and is meant to bring monthly to all its readers a message of inspiration, of cheerfulness and of educational culture.

Winners of Wall Hanging Contest Announced

Mrs. Laura S. Porter, occupational therapist, department art shop, Walter Reed Hospital, Washington, D. C., is announced as winner of the first prize of \$25 for the best wall hanging submitted in the contest sponsored by the New York State Occupational Therapy Association.

The award jury, comprising Wilford S. Conrow, vice-president, New York Society of Craftsmen; Amy Drevenstedt, designer and publisher and formerly reconstruction aid with the American Expeditionary Forces, and Albert Heckman, Teachers College, Columbia University, New York, viewed thirty designs received from professional occupational therapists in Massachusetts, Maryland, Kentucky, Washington, D. C., and New York.

The second prize of \$15 was awarded to Christina

Kelsey, Kings Park State Hospital, Kings Park, New York. Other winners are: first honorable mention, Mary Gilfillan, Manhattan State Hospital, Ward's Island, N. Y.; second honorable mention, P. Caspara Sole, U. S. Veterans' Hospital No. 95, Northampton, Mass.; third honorable mention, Mrs. Sophia Q. Charlton, Home for Incurables, New York City; special honorable mention for peculiar fitness for occupational therapy problem, Emery Sommers, Washington, D. C.

Shall California Continue to Tax Sickness?

Shall California continue to tax philanthropy, sickness and charity?

This slogan has brought definite results to the nonprofit hospitals of California through the recent action of the legislature in passing a constitutional amendment to grant them tax exemption. Voters of the state will pass upon the amendment at the next state election in 1930.

As an indication of what such a law would mean to some of the hospitals, it is pointed out that one nonprofit hospital alone last year paid a tax of \$23,800, or the equivalent of the income from an endowment of half a million dollars.

The campaign for the amendment was carried on by a statewide committee of which G. W. Curtis, superintendent, Santa Barbara Cottage Hospital, Santa Barbara, is the chairman. Dr. Howard H. Johnson, superintendent, St. Luke's Hospital, San Francisco, was chairman of the northern division and G. W. Olson, superintendent, California Lutheran Hospital, Los Angeles, chairman of the southern division. W. C. Crandall, Scripps Memorial Hospital, La Jolla, was chairman of the legislative committee that had in hand the drafting of the amendment. The amendment was sponsored in the legislature by Senator J. C. Crowley, San Francisco, and Senator Edward Mueller, San Diego, both of whom were greatly interested in the measure.

The amendment reads as follows: "Any hospital or sanatorium, charitable or otherwise, within the state of California, not organized or conducted for private profit, shall take and hold exempt from taxation, its property and income, when such property and income are used exclusively for hospital or sanatorium purposes. The legislature shall prescribe the method of determining from time to time the tax exempt status of all hospitals and sanatoriums."

Home and School for Nurses Is Planned

To provide adequate housing facilities for an increased staff of nurses and physicians, the Midway Hospital, St. Paul, Minn., is planning construction of a \$225,000 nurses' home and school of nursing, it is announced.

A citizens' committee of 100 has been formed to head the movement for financing the new unit, funds to be raised in the Northwest generally.

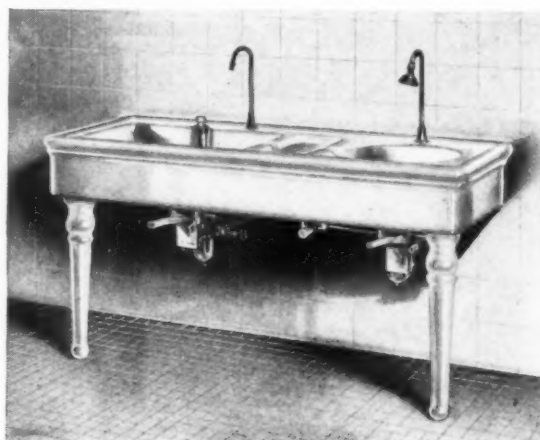
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Modernize your hospital

"One of the growing and proper tendencies is the installation of running water in all patients' rooms and wards. This, in the light of modern aseptic nursing, is almost a necessity," writes Dr. Herman Smith, Superintendent of the Michael Reese Hospital, in the April number of *Hospital Management*.

And yet this is only one of the significant contributions that plumbing has recently made. For the last decade has witnessed in this department practically as many and as important changes as have transpired in medicine itself.

These changes are combining with the enormous amount of new building to render obsolete, in both service and equipment, many older hospitals. A dangerous condition since it threatens the loss of an invaluable amount of bed space.

There is one logical and easy escape from this danger . . . *modernizing*. Given the same equipment a convincing majority of these splendid new institutions are using, older hospitals can be brought to just as high a state of sanitation and efficiency, at a cost incomparably lower than that of rebuilding.

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News of the Month

Semiprivate Patient Department to Be Constructed

Construction is to be started immediately on the semiprivate patient department of the Lenox Hill Hospital, New York City, according to recent announcement.

The new unit, to be built on property owned by the hospital in East Sixty-seventh Street between Park and Lexington Avenues, will be financed by the \$700,000 memorial gift from the sons and daughters of the late George Ehret.

The building will be parallel to the private patient building, similar in design and construction, and both structures will become parts of the new hospital, being joined by a three-story main building.

Many Hospitals Represented at Meeting of Librarians

Representatives of thirty-six hospitals attended a recent meeting of the Association of Record Librarians of Chicago and Cook County held at the Ravenswood Hospital, Chicago.

The program included papers pertaining to departmental records presented by Dr. George de Tarnowsky, Dr. George Baxter, Nan Ewing, Janet Korngold, Dr. A. H. Wolff, Dr. J. J. Moore and Dr. C. A. Buswell.

Construction Work Started on New Unit

Operations were begun recently on the construction of a \$150,000 addition to the Northern Westchester Hospital, Mt. Kisco, N. Y.

Covering an area of approximately 6,640 square feet, the new unit will comprise two wings of two stories each to be built to the rear of the present hospital structure. They will be joined by a new central portion three stories in height. A smaller addition will be constructed on the north side of the hospital.

Methods of Completing Case Records Are Discussed

Ways and means of completing case records before the patient is discharged from the hospital provided the chief feature of discussion at the May meeting of the Philadelphia Association of Record Librarians held at Misericordia Hospital.

Dr. Thomas J. Ryan discussed case records from the doctor's viewpoint. The system used at Misericordia Hospital, where no patient is discharged until the case record is completed and signed, was described by Mother M. Edmonds, superintendent. She pointed out that when a patient is ready for discharge, notification is given to the office immediately. The nurse takes the chart to the

record room where it is carefully checked back. If not properly completed and signed the intern or the attending, or both, are notified of deficiencies. The patient, whether ward or private, is not discharged until the case record is completed, the responsibility for any inconvenience to him resting with the doctor, Mother Edmonds declared.

Two New Hospital Buildings Under Construction in Philadelphia

The new eleven-story building of St. Luke's and the Children's Homeopathic Hospitals, Philadelphia, will be completed in September, it is announced. The new unit, now under construction, adjoins the present buildings of the two hospitals, which consolidated some months ago. The project will cost in excess of \$1,000,000.

Another million-dollar structure now under way in Philadelphia, the Martin Maloney Memorial Clinic, also is expected to be ready for occupancy in September. The clinic will be the third important new medical building addition to the University of Pennsylvania, forming the right wing to the hospital building.

New York Dietitians Hold Last Meeting of the Season

The New York Association of Dietitians held its last meeting of the season at the Russell Sage Foundation, New York City, May 10.

Dr. Ruth Wheeler, Vassar College, Poughkeepsie, N. Y., spoke on "Diet and the Teeth." She told of the various pieces of research that are now being carried on in this field and also mentioned the research work being done that deals with underweight and overweight and their relation to health.

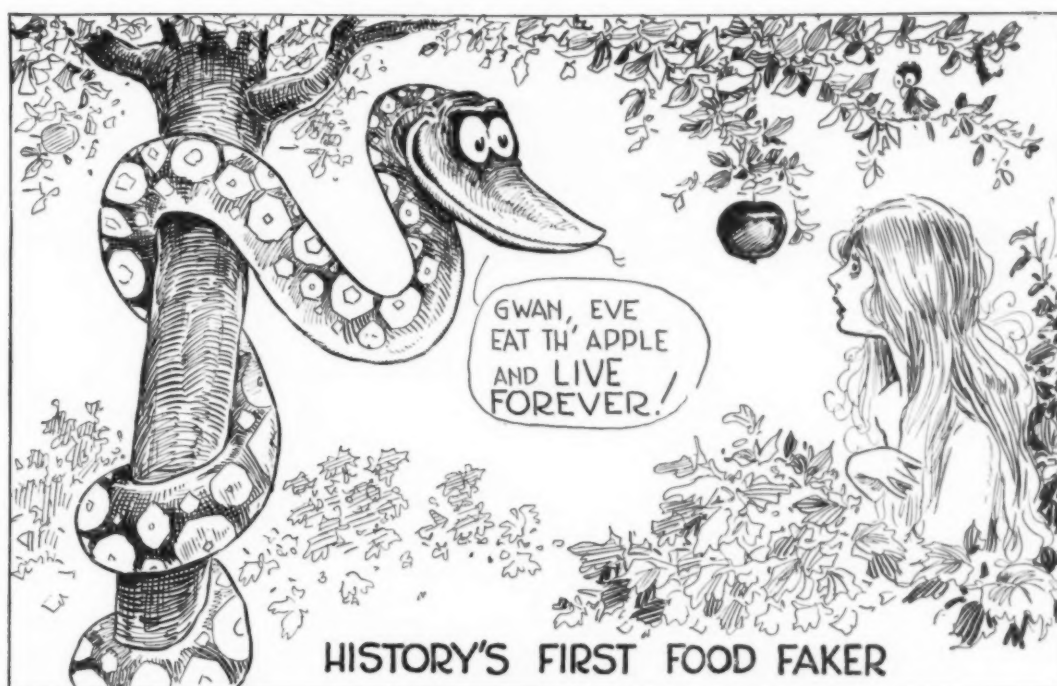
Dr. W. S. Ladd, Presbyterian Hospital, New York City, spoke on the tendency in prescribing diabetic diets. He brought out the fact that insulin may deal with fat metabolism as well as with carbohydrate metabolism.

Mary W. Northrop, Montefiore Hospital, New York City, was in charge of the business meeting. Madeleine Goldsmith read the minutes for the year. Miss Happer read the treasurer's report and Miss Northrop read the president's report. Suggestions were made for next year's policies. It was decided to elect next year's officers by ballot by mail.

Montana Indian Reservation Gets New Hospital

Construction of a \$50,000 hospital at the agency of the Fort Belknap Indian reservation near Harlem, Mont., will be started in July when funds appropriated by the United States Government will be available.

The hospital, with a capacity of fifty beds, will be a much needed addition to the agency health force, it is stated, and will replace a residence building now used.



This cartoon is published in an effort to awaken the public to the danger of following the literature and advice of food faddists or fakers when they should depend on a licensed doctor or dietitian for correct diet information. ☞ To anyone interested, we shall be glad to mail, without charge, a copy of "Facts About Bread and its Rightful Place in the Diet"—a booklet containing statements by the country's most eminent nutritional authorities. ☞ Address Dept. 376, Washburn Crosby Company, millers of Gold Medal Flour, Minneapolis, Minnesota.

News of the Month

Prominent Hospital Superintendent Dies in New York

Friends and associates in hospital work throughout the country will learn with regret of the death of Dr. M. Z. Westervelt, superintendent, Staten Island Hospital, N. Y., who died May 11.

Doctor Westervelt was prominent in activities of hospital organizations and was secretary of the Hospital Association of the State of New York.

New Bronx Hospital Is "Sold" to Contributors

Financed by means of a unique plan whereby every part of the hospital, including equipment, floor space, foundation stones and rooms, were "sold" to contributors, the new Bronx Hospital, New York City, soon will be under construction with virtually all of the cost price, \$2,000,000, already subscribed.

The parts of the hospital were offered to the public at a price ranging from \$100 to \$40,000. The operating room and amphitheater on the eighth floor was priced at \$40,000; the directors' room on the second floor at \$37,500; two bedrooms at \$10,000 each; solariums at \$17,500 each; eight-bed wards at \$30,000; one bedroom at \$7,500; linen room at \$1,000 and elevators at \$7,500 each.

Contributors were permitted to "buy" just what they wanted. Each "buyer" was given honorary title to the purchase, a deed which also conveys life membership in the hospital, and the right to vote at the annual meetings. Donors have priority rights in the introduction of patients to the hospital. The donors are further remembered by a bronze tablet, recording the ownership of each particular room or piece of equipment.

The new hospital is to be a nine-story granite, terra cotta and steel structure, with immediate provision for 310 beds but designed to house 500 eventually.

Special features of the hospital will be solariums fitted with special glass to permit the transmission of the sun's ultraviolet rays and equipped with radio sets. There will also be wall plates in the rooms where the patient may plug in and listen to broadcasts.

There will be a full resident staff of physicians and surgeons and a nursing staff of 110, while the visiting staff will include more than 160 physicians and surgeons. The hospital will be nonsectarian.

Well Known Government Nurse Retires From Service

The retirement of Adelaide Mackereth from service as chief nurse at the Government Hospital, Ancon, Isthmus of Panama, announced in the May issue of the *Trained Nurse and Hospital Review*, recalls the interesting career of one of the most prominent government nurses. Miss Mackereth has just returned from a Mediterranean cruise and expects to settle down in Jamaica.

Her record includes service in three wars, twenty

years' work in the Canal Zone and travel over a large part of the world. Soon after her graduation from the nurses' training school at Medico-Chirurgical Hospital of Philadelphia, she joined the nurse corps formed for service in the Spanish-American War. She served first on the hospital trains and later in division hospitals in Jacksonville, Fla., and Savannah, Ga., fighting typhoid. In 1889 she worked in Cuba and in 1900 in the Philippines.

Following the war Miss Mackereth returned to the United States and retired from the army. A little later, however, war was declared between Japan and Russia and she joined the group of ex-army nurses serving in Japan. In 1905 she entered service in the Canal Zone, where she spent many years fighting yellow fever. In 1912 she became chief nurse of the canal medical section.

During the World War Miss Mackereth served in France for a year and a half with a Friends' Reconstruction Unit. She returned to Ancon in 1920 and remained there until her retirement.

Pennsylvania Hospitals Granted Generous Aid by State

Bills appropriating \$5,922,800 to 175 state aided hospitals in Pennsylvania have been approved by the legislature and Governor John S. Fisher. The appropriations originally totaled \$6,182,000 as passed by both houses but the governor cut \$259,400 from the funds.

The total appropriated was \$422,800 in excess of the budget estimates.

Court Upholds Will Providing Memorial Hospital

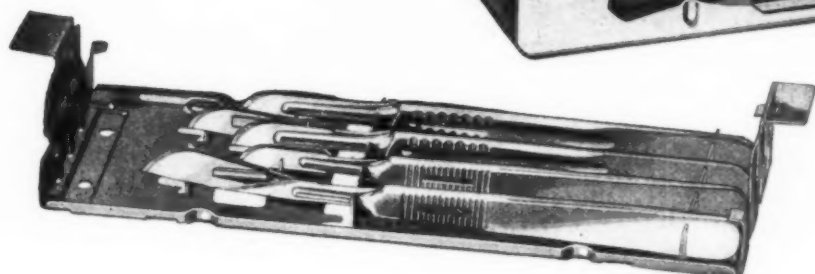
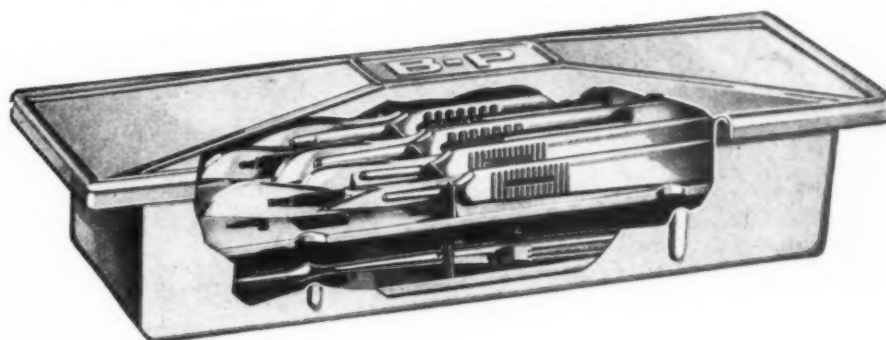
The will of the late Percy Metzger, a lawyer of Washington, D. C., providing that a memorial hospital be founded and maintained from the income from his estate, estimated at not more than \$75,000, has been upheld by the United States District Court of Appeals, despite efforts of his heirs to have the trust declared void. The heirs claimed that the time when the accumulated income would be sufficient to establish and support the hospital is too remote to warrant carrying out the provisions of the will.

In refuting this contention the appellate court declared that "while the will is inartificially drawn, we think it can be upheld and the intention of the testator, as stated in the provisions expressing his desire to establish a memorial hospital, can be so construed as reasonably to admit of execution." The hospital may be established upon a very limited and economical basis, with a view to future extension and development as the income will permit or as gifts and legacies may be left to aid in enlarging and carrying on the charitable work that the testator had in mind.

The will named a group of trustees and authorized them to establish the Percy Metzger Memorial Presbyterian Fund for the hospital.

THE BARD-PARKER STERILIZING CONTAINER

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BARD-PARKER Formaldehyde GERMICIDE

The Bard-Parker Sterilizing Container for hospital and office use is especially designed for the sterilization of Bard-Parker Knives.

Material: Monel metal which possesses long life and is easily cleaned.

Construction: Two removable trays with racks for handles and blades.

Capacity: Eight Bard-Parker Knives with blades attached and space for extra blades.

Efficiency: The trays may be lifted out of the Container and set on top to drain. Knives are ready for use without rehandling.

Price: Container with two trays (not including knives) \$10.00.

Write for circular giving complete description of Bard-Parker Sterilizing Container and formaldehyde Germicide.

A powerful, non-corrosive sterilizing medium of high germicidal efficiency prepared especially for sterilizing Bard-Parker Knives and other fine surgical instruments.

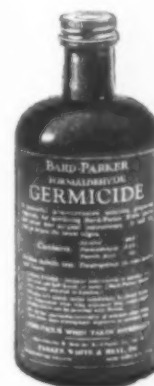
Bard-Parker formaldehyde Germicide: Destroys the most resisting non-spore-bearing bacteria in less than two minutes.

Destroys the most resisting spore-bearing bacteria in one and a half hours.

Does not injure the keen edge of Bard-Parker blades or other fine steel instruments after two weeks' constant immersion.

Prices:

One pint bottles	\$1.00 each
One carton (12 pints)	10.80
One gallon bottles	5.00 each
One carton (4—1 gal.)	18.00



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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

Training Young Women for Navy Duty in Schools of Nursing

By J. BEATRICE BOWMAN
Superintendent, Navy Nurse Corps

ALL nurses should know the status of the navy nurse. Officers are commissioned, nurses are appointed and the men are enlisted. Although the nurses do not actually have relative rank, they are classed as officers in respect to privileges and to matters pertaining to the performance of their duties.

Often letters are received from nurses saying they would like to enlist for the nursing work in the navy and many of them add that they want to serve on the battleships. It is natural to think of battleships when one thinks of the navy, and it is also natural to think that the men on the fighting ships are the ones who need the services of trained women nurses. But nurses do not go on the battleships and they do not enlist for service. The distinction of these terms is emphasized since they connote material differences in status and privileges.

A young woman who takes up nursing as a profession must realize that she is entering upon a life of service. The life is not all that the poets write about and a great deal of the romance is lost before the training is completed; but when a nurse gets her diploma, she has learned to combine romance and service and is ready for the many-sided life that is required of a trained nurse.

During her training days, she learns that the life is

conducted more or less according to military standards, and she prepares herself mentally to adjust her life to the requirements and to obey the necessary regulations and orders. Her success will lie in her capacity for integration. If the nurse is interested in her work and has conscientiously applied herself to her course in training, and if the training has been received in an accredited general hospital, there is little doubt but that she will be successful in any special field of nursing that appeals to her.

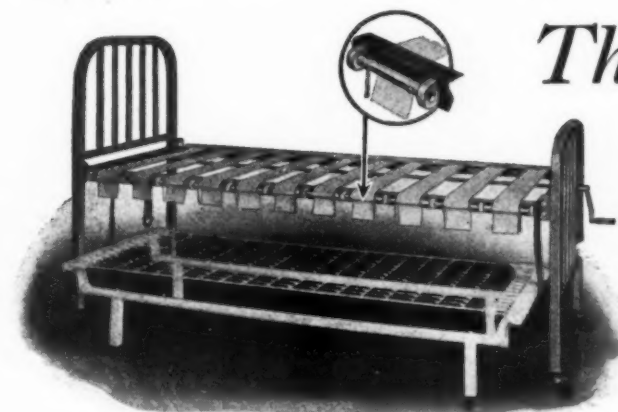
The nursing work in the navy is different in some respects from the work in civilian institutions. The same fundamentals are required of the nurses. In order, however, for the nurse to be happy in her work and to make a success of it, she should have natural executive ability or be given an opportunity to acquire it, and she should be able to impart her knowledge to others. Since her patients, as a rule, are men, as are many of her co-workers, she must be able to govern large groups of men without antagonizing them.

Student nurses in the hospitals are much younger than they were ten or fifteen years ago. The curriculum in the schools of nursing has been enlarged, graduate nurses as a rule are in charge of many of the departments and the student has neither time nor opportunity to gain



Practical instruction in dietetics, U. S. Navy Hospital Corps Training School, Mare Island, Calif.

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St. Mary & Elizabeth Hospital, Louisville, Ky.
Methodist Hospital, Memphis, Tenn.
Colgin Hospital and Clinic, Waco, Texas.
German Deaconess Hospital, Chicago, Ill.
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Mercy Hospital, Springfield, Mass.
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Trinity Hospital, Minot, N. D.
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Piedmont Hospital, Atlanta, Ga.
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St. Joseph's Hospital, Stockton, Calif.
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Mercy Hospital, Ellwood, Ind.
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St. Mary's Hospital, Passaic, N. J.
Bayonne Hospital, Bayonne, N. J.
Finley Hospital, Dubuque, Iowa.
Bethesda Hospital, St. Paul, Minn.
St. Mary's Hospital, Orange, N. J.
Orange Memorial Hospital, Orange, N. J.
Mercy Hospital, Iowa City, Iowa.
Mercy Hospital, Des Moines, Iowa.
Christ Hospital, Cincinnati, Ohio.
Mercy Hospital, Columbus, Ohio.
St. Joseph's Hospital, Ottumwa, Iowa.
Crary Hospital, New Bedford, Mass.
Burnham City Hospital, Champaign, Ill.
Schneck Memorial Hospital, Seymour, Ind.
Burlington Hospital, Burlington, Iowa.
Homeopathic Hospital, E. Orange, N. J.
The Memorial Hospital, Piqua, Ohio.
Broken Bow Hospital, Broken Bow, Neb.
Clinica Bustamante Nunez, Havana, Cuba.
John H. Murphy, Geneseo, Ill.
St. Francis Hospital, Burlington, Iowa.
Hall & Bennett, Big Springs, Texas.
Rosenkrans Hospital, E. Stroudsburg, Pa.
Reid Memorial Hospital, Richmond, Ind.
Harper Hospital, Detroit, Mich.
St. John's Hospital, Springfield, Ill.
St. Mary's Hospital, Decatur, Ill.
State University Hospital, Iowa City, Ia.
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Monroe County Hospital, Stroudsburg, Pa.
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Deaconess Hospital, Bozeman, Mont.
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Drawing room, nurses' quarters, U. S. Naval Hospital, San Diego, Calif.

much executive experience. Many young nurses who receive an appointment to the Navy Nurse Corps resign at the end of six months' service because they feel that they are unable to manage a large ward. To be successful in the navy, a nurse should have had previous executive experience. If she is unable to obtain it during her period of training then she may secure it through post-graduate work.

In addition to the medical officers and the nurses, there is an organized group of men known as the Hospital Corps, which numbers approximately 4,000 men. The nurses are responsible for the nursing instruction of the hospital corpsmen, who in turn are responsible for the care of the navy sick and wounded aboard the ships to which nurses are not assigned. These men are assigned to duty, also, with the U. S. Marines.

It will be seen therefore that the personnel of the Navy Nurse Corps must be composed of young women who are interested in teaching as well as in the care of the sick. It is a known fact that practical work, or practical training, occupies the greater part of the students' time and energy and the educational factors that develop supervisors and teachers are often neglected. As the character of the navy nurse's work involves constant supervision and instruction of the hospital corpsmen, she should have a more liberal theoretical foundation upon which to develop these qualifications than is ordinarily included in the general scheme of training nurses in the schools of to-day.

There are two schools for the training of the hospital corpsmen, one at Portsmouth, Va., and the other at San Diego, Calif. Four months' theoretical and practical training are given, and the schools are equipped with every convenience and device for teaching. The staff of instructors at the schools is composed of officers, nurses and trained enlisted personnel. From these schools the

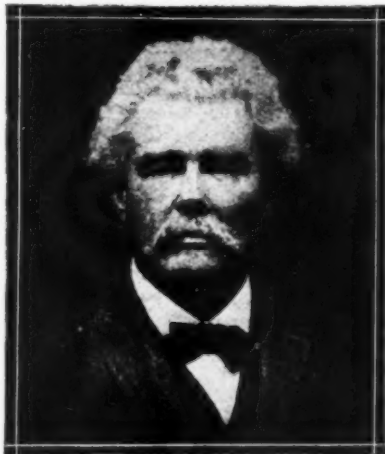
corpsmen are transferred to naval hospitals where instruction in advanced nursing is taken up and the men gain experience in the various departments similar to that of the nurses in civilian hospitals.

At all the large hospitals nurse instructors carry on the follow-up work. These instructors are usually nurses who have had a period of duty at the Hospital Corps training schools, and thus they have a thorough knowledge of what the men must learn before they leave the school. The instructors at the hospitals continue the classes in both theoretical and practical work and visit the wards to supervise any special treatments or procedures. The hospital corpsman thus is taught correct methods at the beginning of his hospital work.

The nurse in charge of the ward supervises the work carried on by the corpsmen but, with her many duties, it is not always possible for her to find time to teach new procedures. The follow-up nurse works in conjunction with the ward nurse so that there are always efficiency and harmony in the teaching.

The bureau of medicine and surgery, fully alert to progress and development, encourages its nurses to keep in touch with their professional organizations and it provides tuition for such postgraduate courses as will benefit the individual as well as the service. After a period of three years, the length of time necessary for adjustment to the peculiarities of the naval service, requests for courses in physiotherapy, anesthesia, laboratory and dietary work are given favorable consideration. Due to the fact that a nurse is on duty but eight hours during the day she can plan time for such study and recreation as may appeal to her. Many of the nurses improve their off duty time with study, music or lectures, and enjoy the educational advantages, geographic and historic, that abound in the various places where naval hospitals are situated.

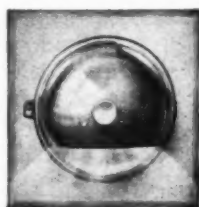
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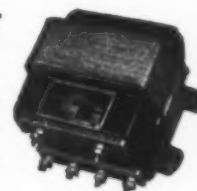
A line has been extended, broadened, developed. ★ Edwards signals in many of the world's hospitals.✓ phases.✓ Nothing more than the practical a perma- Example:-



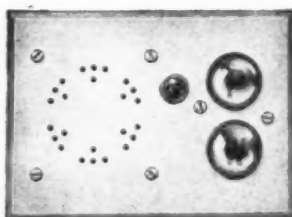
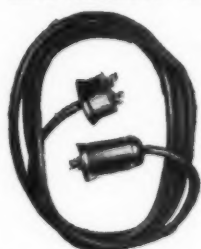
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★Illustrations on this page taken from "Modern Hospital Signaling". Copy upon request.

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Hospitals may be found on the east coast at the following places: Portsmouth, N. H.; Brooklyn, N. Y.; Washington, D. C.; Pensacola, Fla.; Chelsea, Mass.; League Island, Pa.; Quantico, Va.; Newport, R. I.; Annapolis, Md., and Norfolk, Va.

In eastern tropical waters there are stations at: Guantanamo Bay, Cuba; St. Thomas, V. I.; Port au Prince, Haiti and St. Croix, V. I.

In the Middle West the hospital is at the Naval Training Station, Great Lakes, Ill.

The west coast hospitals are located at: Bremerton, Wash., Mare Island, Calif., and San Diego, Calif.

Tropical stations in the Pacific Ocean are at Pearl Harbor, Honolulu, Samoa, Guam, M. I., and Canacao, P. I.

Nurses find great pleasure in taking leave of absence at all stations to visit such countries as their time will allow. From Samoa it is possible to reach Australia. Nurses in the Philippine Islands visit China and Japan. Naval transports carry two nurses. Two hospital ships, the U. S. S. *Relief* with its complement of twelve nurses, and the U. S. S. *Mercy* with six navy nurses, are attached to the fleets.

In addition to the teaching of members of the Hospital Corps, navy nurses are responsible for the training of native women nurses in our island possessions. Guam, Samoa and the Virgin Islands have their own problems in caring for the natives of the islands and the navy nurse must provide not only the training in nursing but she must also give instructions in the three R's. As a result the health and welfare of the islands have been benefited and great advancement in hygiene and healthful living has come about. Many of the native nurses become midwives and a close check is kept upon them throughout the islands. There is a "visiting" navy nurse in the island of St. Croix, Virgin Islands, who, accompanied by a native graduate nurse, visits the sick in the villages throughout the island. Two municipal hospitals, one at Christiansted and one at Fredericksted, are under the navy medical department.

Nurse Corps Requirements

The requirements for appointment in the Navy Nurse Corps are as follows: An applicant must be a registered nurse, a citizen of the United States, single and between the ages of 22 and 35. She must be a graduate of a school of nursing whose educational and professional standards are approved by the surgeon general of the navy.

Physical examinations are rigid due to the fact that nurses must be physically strong enough to perform duty in all climates and under all conditions. The government must be protected also, for there is great expense involved in ordering a nurse to duty. A bill has been introduced in Congress granting retirement for disability in line of duty. Should the measure become a law, even more care must be taken to protect the government from those who are liable to become a physical risk before they have given much service.

Many young women fail to pass the required physical examination. During their period of training the students are well supervised and minor illnesses are corrected, but after the nurse has left her training school she does not always check up on her physical condition.

The importance of an annual physical examination cannot be too strongly impressed upon the nurse. In a great many instances, disabilities may be corrected if taken in time. If they are neglected, they become permanent and may bar the nurse from obtaining any position where a physical examination is one of the requirements.

All nurses, although they may have no desire to devote their life to government nursing, should be prepared to respond to the call to the colors and to understand the conditions and requirements of the naval service. That a nurse can calmly walk into the work and give valuable cooperative service instantly is by no means possible. The life as well as the language is different and one finds herself thinking and speaking in nautical terms as do the men. The regulations of the service and the psychology of the men as well as the life in general are interesting and instructive. A nurse who has spent three years in the United States Navy may resign with an honorable discharge.

A section has been reserved at Arlington for those who have given service, and nurses who so request may be buried there with full military honors. And when the volleys speak and the taps resound over the hills, she is left to rest with her comrades and to be honored by her country among its living dead.

Making Nursing School Directors Partners in Hospital Affairs

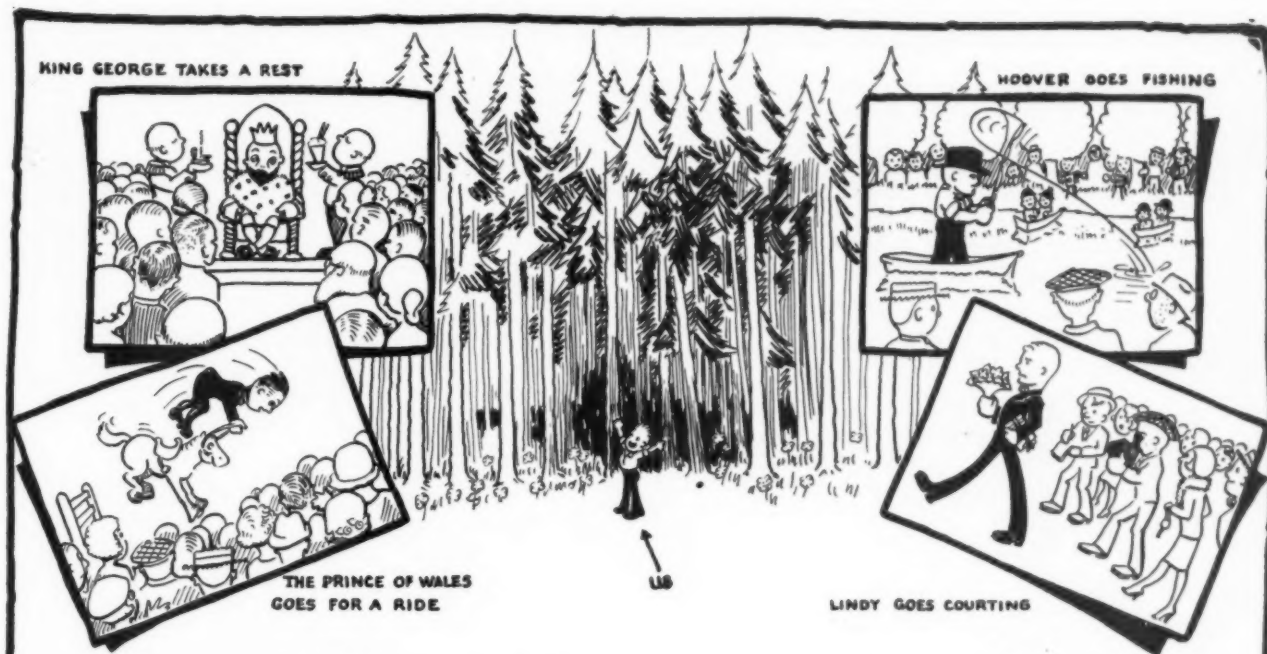
That the nurse in charge of the school of nursing can obtain more satisfactory results if left free to work out her own plans is the opinion of Martha M. Russell, R.N., superintendent, Camden-Clark Hospital, Parkersburg, W. Va.

"No woman can feel that she is responsible for her department," Miss Russell writes, "if her plans are all overruled without consultation, the salaries of her assistants altered without her recommendation and information that is given by orderlies and maids accepted as a basis for official action.

"In his address on 'Courage,' Barrie urges youth to demand a partnership from its elders that the work of the world may be well and wisely done. It seems that the nurses who administer the schools for nurses should demand a partnership in the affairs of the institution that the service to the sick may be of the highest type and that they may carry on under a steady sense of responsibility to accomplish their own share of the task. "In this country, we began with the idea—new in Washington and Jefferson's time—that the object of government is justice for those governed, and administrative, legislative and judicial branches were established to attain that end. Although no one claims that the results are perfect, there are few persons who do not consider it worth while to go on with the experiment.

"In hospital organization, the good of the patients actually in the beds as well as the good of those who will be cared for in years to come by the nurses and doctors studying in the institution is the end sought. If each question of policy and administration is considered with reference to this end, small and petty problems of authority will not assume undue importance. While the immediate results may be less striking than under a highly centralized power, the development of an institution dedicated to health will be broader and more gracious.

"There may be times when an emergency demands a brief dictatorship, but on the whole the more completely the spirit of partnership dominates the situation, the better will be the care of the sick, the teaching of the novitiates in medicine and nursing and the personal development in resourcefulness, initiative and reliability of the individuals making up the staff."



If it weren't for our jobs and a number of things
I'm sure we would all be as happy as Kings



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FOR instance, when we go away on vacation one of the things that sometimes bothers us is how under the sun the old world is getting along without us. It does limp along somehow, but the spectre of unfinished and accumulating business begins to disturb our slumbers and take the edge off our enjoyment along about the third day out. And the last two or three days before we return! Visions of desks piled high with memo's, want sheets, reports of unforeseen material shortages, etc., etc., ad inf. — it's enough to undo all the good of the whole vacation. A vacation should really rise to a climax, a crescendo, at the very end and leave us with a glorified "Oh, Boy!" feeling.

You'll enjoy your vacation more and make the work easier and more pleasant for those you leave behind you if you make sure now that your institution will be adequately supplied with everything needed to do effective work during your absence. Don't put the matter off. Do it early while you can do it thoughtfully. Our catalog will give you details on all needed supplies. If your copy has been mislaid we'll gladly send you another. Or you may send your open order. It will be filled properly, carefully and at correct prices. Shipment will be made at any time you desire. We'll appreciate this opportunity of serving you and helping to make your vacation pleasanter.

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SUPPLIES

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Achieving and Maintaining High Dietary Service Standards

By MALCOLM T. MACEACHERN, M.D., C.M., D.Sc.

Director, Hospital Activities, American College of Surgeons

HOSPITAL service is composite in character, being made up of various units contributed through many sources. One of the most important of these units is the dietary department. It has been estimated that this department in hospitals is responsible for 1,500,000,000 meals annually, which consumes 25 to 30 per cent of the budget or approximately \$250,000,000 to \$300,000,000. This alone warrants the serious attention of hospital executives, dietitians and other interested persons not to say anything of the rôle the department plays in the treatment of disease or diet therapy.

In recent rapid developments in hospital management none stands out more prominently than improvement in the dietary service. This has been due to more efficiently planned and equipped dietary departments, more competent administration and the adoption of carefully worked out procedures so that in the present day it is only reasonable to expect every progressive hospital to have a properly planned, equipped, organized and administered department under the supervision and direction of a competent graduate dietitian whose training conforms to standards approved by the American Dietetic Association. This department should have full responsibility for the entire food service of the hospital including (a) efficient administration of the general food service, (b) scientific dieting of patients and (c) the education of student nurses, student dietitians and medical students in dietetics as related to disease. This covers the rôle of the dietitian in hospital service.

Careful Study of Needs Advised

Adequate physical facilities for carrying on administrative and teaching functions of the dietary department presuppose proper planning and construction which should be done with due consideration and after careful study of the needs of the particular hospital. A complete department includes the following units: dietitian's office; main and special diet kitchens; cleaning, storage, refrigeration and other service requirements all of which are now well standardized; well equipped classroom and laboratory for the education of student nurses and student dietitians.

The physical arrangements of the department should receive careful and scientific thought in order to provide an efficient and economical service through the proper coordinating or correlating of the various facilities. In the planning of the department, the advice of the dietitian of the hospital or a consulting dietitian should be secured. If such a person is competent and wide awake to present day advances she should be able to contribute valuable practical advice.

Close Cooperation Is Important

A careful analysis of the hospital organization and functions and relationships of the dietitian reveals a close association of the latter with the actual administration of the hospital in its four major phases, namely, business, medical, nursing and education. On this account there must be the closest cooperation between the dietitian and the various groups in the hospital.

It is quite apparent that the dietitian has a close relationship as well as a serious responsibility to the business department of the hospital through the food budget which, it has already been pointed out, amounts to 25 to 30 per cent of the entire maintenance budget of the hospital annually. The dietitian must regulate the food budget in order to effect every possible economy consistent with a high standard of service. There must be at all times the closest cooperation between the dietitian on the one hand and the superintendent and business manager on the other.

To-day we recognize an ever increasing closer relationship between the dietitian and the medical or clinical aspect of the institution. Diet therapy in recent years has been a rapidly developing phase of medicine and has brought the dietitian into closer relationship with the clinician in the observation, diagnosis and treatment of the patient in a special group of diseases. It has brought her into closer contact also with the laboratory worker through recent developments in blood chemistry and diseases of metabolism. In fact, the services of a competent dietitian are indispensable to the scientific practice of medicine.

Of increasing importance is the relation of the dietitian

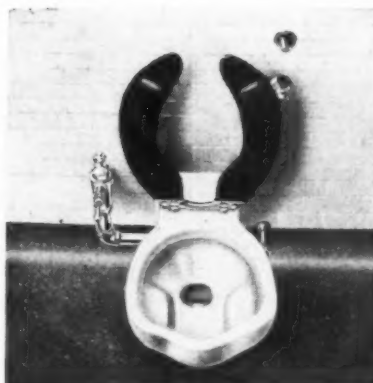


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to the educational aspect of the hospital. She must be responsible for the teaching of dietetics to student nurses and frequently to student dietitians and medical students. In no other way can the student nurse be properly taught the subject of dietetics. Frequently the dietitian can further the cause of preventive medicine through contact with various groups in the community to whom she can teach and demonstrate food values, proper dieting and other matters pertaining to better health and community welfare from the standpoint of food and nutrition.

Status of Dietitian Well Established

The duties of the dietitian, therefore, may be regarded as mainly administrative, scientific and teaching. Her status is now well established. Her services are absolutely essential. Without her no progressive hospital can function to the greatest benefit of the patient.

An adequately trained staff is required for administrative, technical and general service in the dietary department. Members of the personnel should be competent in their respective fields of duty. It is most important that all employees of the department meet definite physical, mental and character standards consistent with high-class and efficient service. Too much attention cannot be given to the building up of a permanent personnel, each member of which must be competent in his or her particular sphere regardless of the type of service given. Efficiency, industry and good morale are valuable indexes of a properly functioning dietary department that reflects itself particularly in a satisfied clientele—patients and employees.

As in all other departments of the hospital, there must be an adequate system of records embracing administrative, business, clinical and technical aspects. It is impossible to run this department successfully without a well organized record system that at a glance reveals its organization, personnel and assignment of duties, working schedules, food specifications, inventories, requisitions, costs, diet lists, lectures and demonstrations. Good records here are as essential as they are in the operating room, clinical laboratory, x-ray or other departments of the hospital. They are the basis for smooth running and efficient service.

Director Develops Rules

The director of the department or chief dietitian and staff, with the approval and cooperation of the superintendent and board of trustees or governing body, should initiate and develop rules and regulations pertaining to the policies of the department. These rules and regulations should especially provide for departmental and interdepartmental conferences at regular intervals for the review of activities of the department in order to appraise the work and to make adjustments or improvements necessary to promote efficiency of the service. Through conferences any deficiencies or lack of cooperation can be eliminated. The dietitian, with her own group in conference can do much to promote interest and efficiency in her department; by sitting in on the general administrative conference she can do much to promote better cooperation with the other departments of the hospital. The whole scheme of conferences of this nature in hospitals is predicated on the basis of promoting the six fundamental principles of hospital administration, namely, organization, cooperation, coordination, efficiency, economy and service. These principles must permeate all hospital activities and particularly the dietary service.

In this discussion it would not be amiss to emphasize the importance of good leadership. More than ordinary or average ability is required to handle successfully a well organized and properly functioning dietary department. It is exceedingly important that the dietitian be well balanced in her training. This work involves, to a major extent, administrative functions in addition to the technical and teaching aspects. Successful administration of the dietary department along the broader lines discussed herein presupposes leadership in administrative, technical and teaching functions. It is exceedingly important that the dietitian shall maintain a broad viewpoint on this matter and bear in mind that all her work must be measured or appraised in terms of service to the patient. This, after, all, is the most worthy objective possible and is the chief reason for justifying her existence as an important member of the highly specialized hospital family.

Service Standards Listed

To sum up:

1. The recent and rapid developments in improved dietary departments in hospitals is an important outstanding factor in promoting better service.
2. The increasing magnitude of the work of the dietary department in hospitals warrants close observation and serious consideration at all times.
3. Every progressive hospital should have a well organized dietary department under the supervision of a competent graduate dietitian.
4. The dietitian when properly functioning has close working relations with the business, medical and nursing phases of the hospital.
5. An efficient dietary department presupposes careful planning, constructing and equipping with due regard for the proper correlation of the various units to save time and energy and to expedite the service.
6. Due consideration should always be given to providing the necessary administrative, service and teaching facilities.
7. A complete system of departmental records showing actual performance is essential.
8. Departmental and interdepartmental conferences are desirable to promote better cooperation and coordination in the work of the department.
9. The dietitian should have well balanced training and experience, always bearing in mind that the major part of her work is of an administrative nature.
10. The dietary department is an integral part of the hospital organization and service to the patient is its primary objective.

Ketogenic Diet in Epilepsy Is Basis of Study

Merits of the ketogenic diet and acid producing drugs in the treatment of epilepsy are being considered in a study now under way at the Chicago State Hospital, according to the *Illinois Medical Journal*.

Eighty patients are under treatment with a special dietitian in charge of the menus. The diet is such that the patients do not object to it. Nursing is supervised by nurses from the state school for psychiatric nursing. Laboratory work to determine the changes in metabolism is a definite part of the research. The study will not be completed for several months.



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Baby Health Stations and Family Budgets*

By MARGARET H. LYMAN

Associated Out-Patient Clinics Committee, New York Tuberculosis and Health Association

HOW much money have the families who take their babies to baby health stations? In what sort of homes do they live? How many are able to afford anything beyond the bare necessities of life? How many of them have comforts, healthful recreation and entertainment as well as necessities?

To find the answers to these questions and a number like them was the purpose of a study made in the Fall of 1928 by the Bronx Committee of the New York Tuberculosis and Health Association. This study undertook an investigation into the economic status of the clients of baby health stations in order to obtain data that would present concretely facts concerning the economic situation of these people.

No attempt is made to answer decisively the question as to who should and who should not be eligible for a free preventive medical service such as that offered by baby health stations. Still less is it the purpose of the study to determine the ability to pay for curative medical care. The hope is, however, that the material here presented will serve to remove the consideration of this whole matter from the realm of generalities and make clear some of the problems involved.

Trained Workers Make Investigation

Trained workers were sent into the homes of a selected number of clients of the thirteen baby health stations in the Bronx. The families visited were chosen at random from among those actually attending the health stations during either September or October 1928, the number selected from each station representing about 15 per cent of the station's total registration. Home visits were then made to obtain from the parents information on points such as the size and character of the family, the occupation of the chief wage earner, the family income, savings, certain expenditures and debts.

The field investigation was carried on by four social workers and extended over a period of three weeks. Visits were made to 722 families. The investigators, however, were unable to obtain sufficient information

about 221 families, or 31 per cent, to warrant including them in the study. The present study is concerned with the returns from 501 families representing approximately 10 per cent of the total estimated registration of baby health stations in the Bronx.

Before analyzing the data in these 501 returns, it seems desirable to point out some of the difficulties encountered in collecting and interpreting material of this general character.

Reliable Facts Difficult to Obtain

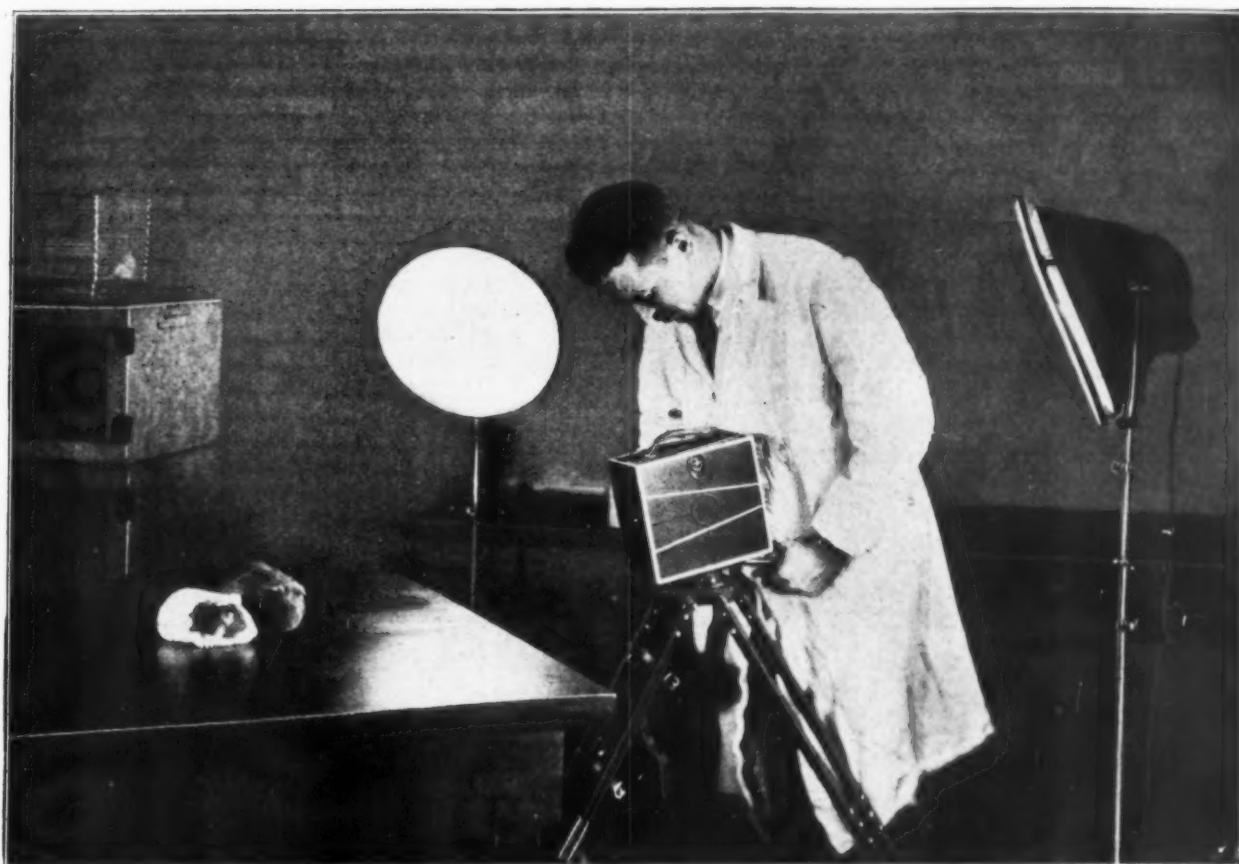
Entirely reliable facts on income, expenditures, debts and savings are difficult to obtain even under the best of circumstances, which presuppose a more carefully guarded schedule, more intensive supervision of investigators and a more careful checking of statements than were feasible for the present study. A preliminary examination of the returns made it apparent that a direct tabulation of the data as they stood would have involved some serious inaccuracies. Considerable interpretation and estimation were necessary in order to harmonize certain statements with what other information and common sense indicated as reasonable.

The following points represent those at which such estimation and interpretation were necessary:

1. Wages seemed to be understated in many cases. These have been adjusted after some general checking with published statistics.
2. Statements of the duration of unemployment reported in the schedules seemed excessive in the great majority of cases. These have, therefore, been scaled down to conform more nearly with information furnished by published statistics and general information from labor and employers' associations.
3. Income from boarders and children has been adjusted to represent estimated profit.
4. The size of the family has been adjusted to represent as nearly as possible the total number of individuals supported by the income reported.
5. Rents for cold water flats and houses have been adjusted to cover heating in order to make them comparable with the amounts paid for apartments that are heated.

In using the material in the study, therefore, it is im-

*Summarized from a study of the economic status of 501 families in the Bronx in 1928, prepared by Margaret H. Lyman, New York Tuberculosis and Health Association, for the Bronx Tuberculosis and Health Association at the request of the public health committee, Bronx County Medical Society, New York.



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portant to bear in mind that the summarized data represent estimates based on the statements of the families interviewed. The statistical summaries should be considered as approximations of the economic status of these families and not as purely factual material.

What are the living conditions indicated by the statements of the 501 families interviewed? In 87 per cent, the father is a wage earner working in a factory or at a trade. The size of the family, including relatives supported, varies all the way from two to eleven members, the majority of families having from three to five members each. Eighty-five per cent of the families occupy flats of four rooms or less. More than one-fourth of them are living under unhealthful conditions.

In Table I are shown the estimated total incomes for 1928. According to the table the incomes range from

TABLE I—ESTIMATED TOTAL ANNUAL INCOMES OF 501 BRONX FAMILIES REGISTERED IN BABY HEALTH STATIONS FOR 1928

<i>Estimated Annual Incomes</i>	<i>Number of Families</i>	<i>Per Cent of Total</i>
\$1000 and less	4	.8
1001 — \$1200	18	3.6
1201 — 1400	38	7.6
1401 — 1600	54	10.8
1601 — 1800	45	9.0
1801 — 2000	111	22.1
2001 — 2200	69	13.7
2201 — 2400	48	9.6
2401 — 2600	47	9.4
2601 — 2800	22	4.4
2801 — 3000	17	3.4
3001 — 4000	27	5.4
Over 4000	1	.2
Total	501	100.0

\$1,000 and less for four families to more than \$4,000 for one family. Only sixty-seven families, 13 per cent of the total, reported incomes of more than \$2,600 a year, or \$50 a week. More than three-fourths of the families reported less than \$50 a week income. Almost one-third reported incomes of less than \$1,800, or \$35 a week.

Statements of incomes, however, if they are to mean anything at all, must be considered in connection with the cost of supporting a family of a given size in accordance with definite standards of health and comfort. In other words, what does it cost these Bronx families to live? Do the incomes they report provide them with luxuries, with moderate comforts or only with necessities? Are there any families whose incomes would not even provide necessities?

Cost of Shelter and Heat

What is the situation in regard to the cost of shelter and heat for example? According to Table II, a few more than half the families reported a rent and heat expense of from \$451 to \$600 a year, or from \$37.50 to \$50 a month. About one-third reported that they paid less than \$37.50 monthly which leaves only 14 per cent who paid more than \$50 a month for rent and heat combined.

What does it cost these 501 families for the other items entering into the total cost of living, such as food, clothing, housekeeping equipment, gas, electricity, car fare, toilet necessities, drugs, medical care, education, recreation, insurance, savings, church, charity, gifts and other sundries? Numerous studies of family budgets have been made at various times. Studies have also

been made of the cost of the different classes of items that make up the total cost of living for families in given circumstances.

The most recent of this budget and cost of living material has been brought up to date and used as the basis for five budgets that suggest the total cost of living for a family of five, with three children under fourteen years old, living in the Bronx in 1928 under five different sets of circumstances. Table III gives the total value of each budget, the amount allowed for medical care and drugs and a general statement of the circumstances of living possible for a family of five living in the Bronx in 1928 on the income indicated by the total budget.

According to these budgets a family of five living in the Bronx in 1928 could not even maintain itself physically on less than about \$1,400 a year. The family of five living on Budget A in Table III lives in poverty and dependence. Budget B, allowing \$1,440 a year, barely provides for physical maintenance of the family, without allowing for emergencies of any sort. Neither would there be provision for medical care, old age, education or pleasures that cost money. This budget was based on budget material from the New York Charity Organization Society, Cleveland Associated Charities, Detroit Visiting Housekeepers' Association and others.

Budget C, with \$2,150 to spend, provides healthful and decent living for this family of five, but it does not provide comfortable living. This budget is based on a study of the cost of living for the Bronx in 1926 made by the National Industrial Conference Board, a manufacturers' association. The budget represents decent housing, enough food of a quality to maintain health, cheap but neat clothing, enough money to provide for cleanliness and the maintenance of a minimum of household equipment, and small allowances for medical care and drugs, education, recreation and savings.

Budgets D and E, \$3,240 and \$3,670, have for their basis a budget study made by the United States Bureau of Labor Statistics in 1919. Budget D represents minimum comfort for an industrial worker's family. Budget

TABLE II—ESTIMATED ANNUAL RENT AND HEAT EXPENSE FOR 501 BRONX FAMILIES FOR 1928

<i>Annual Rent Including Heat</i>	<i>Number Families</i>	<i>Per Cent</i>
\$300 and less	38	7.6
301 — \$350	10	2.0
351 — 400	45	9.0
401 — 450	65	13.0
451 — 500	90	17.9
501 — 550	99	19.7
551 — 600	81	16.2
601 — 650	21	4.2
651 — 700	27	5.4
701 — 750	11	2.2
Over 750	14	2.8
Total	501	100.0

E represents the same circumstances for a professional man's family. These budgets allow for a greater variety in food, a better quality and greater variety of clothing, better living quarters, furniture for minimum comfort, telephone service and greater leeway for medical care, education, recreation and savings. Space does not permit the presentation of these five budgets in detail.

In these five illustrations of the cost of living for a Bronx family of five, each income provides a different set of living conditions ranging from poverty on less than \$1,400 to minimum comfort on \$3,240 to \$3,670. Of these



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five sets of living conditions which ones best illustrate the living conditions of the 501 families using baby health stations?

Table IV answers this question. In this table both the incomes reported by Bronx families and the incomes represented by the budgets just discussed are expressed in terms of income per adult member of the family. This means that the actual number of individuals living on the income reported has in each case been reduced to equivalent adult units, using a standard scale, which is based

TABLE III—SUGGESTED YEARLY BUDGETS FOR A FAMILY OF FIVE LIVING IN THE BRONX IN 1928

Total Budget	Allowance for Medical Care and Drugs	How the Family Lives on Budget
A. Below \$1,400	\$ 0	In poverty and dependence
B. \$1,440	25	In bare physical maintenance
C. 2,150	75	In health and decency—not in comfort
D. 3,240*	200	In bare comfort
E. 3,670**	200	In bare comfort

*Family of industrial worker.

**Family of professional worker.

on relative food consumption of individuals of different ages.

Each family's income is then expressed in terms of the income available for each adult individual in that family. This makes it possible to compare incomes of families of different ages and sizes. Because of special circumstances in New York City, necessitating in many cases the payment of higher rent than a family ought to afford, it seemed desirable to show here the income available for each adult individual of the family after deducting annual rent and heat expense.

Table IV shows that thirty-six families have a yearly income, after deducting rent and heat expense, of \$300 or less for each adult member of the family. According to our cost of living budgets, this amount would place these thirty-six families, 7 per cent of the total, in circumstances of poverty and dependence. One hundred and thirty-two families are indicated as having from \$301 to \$500 per adult member. This means that these families, 26 per cent of the total, are barely able to maintain themselves physically and have no reserve funds for emergencies of any sort.

Two hundred and twenty-seven families, representing almost half the total, have incomes ranging from \$501 to \$800 per adult individual after rent and heat bills are paid. These families have sufficient funds to provide for decent and healthful living conditions without, however, any surplus for comforts, or for savings for old age or emergencies. Sixty-seven families, 13 per cent of the total, are indicated as having from \$801 to \$1,000, which, according to the budgets, would provide these families with limited comfort and modest reserves for medical emergencies and savings, but not for luxuries.

Finally, there are thirty-nine families with yearly incomes, after deducting rent and heat, amounting to more than \$1,000 per adult member. These families, comprising 8 per cent of the total, appear to have a surplus of funds over and above what the budgets allow for a minimum of comfortable living.

In summing up it is found that more than three-fourths,

actually 79 per cent of the 501 families studied, reported incomes which according to cost of living budgets do not provide for more than decent living under conditions of health. Thirteen per cent of the total earn enough to live in limited comfort, while 8 per cent have a surplus over and above minimum comfort.

Detailed information on debts and savings would have made an interesting and valuable contribution to the economic picture of these families. No attempt was made to obtain detailed evidence on these points because of the time and expense involved in testing its reliability. Answers to the general questions in the questionnaire indicated, however, that 43 per cent of the 501 families were in debt for current living, the purchase of household equipment, doctors' bills or for loans to cover business losses or unemployment.

In regard to savings, 11 per cent of the families studied, stated that they had no savings whatsoever, not even insurance. Sixty per cent stated that they had only insurance. Twenty-two per cent stated that they had both insurance and other forms of savings. Two per cent reported other forms of savings but no insurance, while 4 per cent failed to state the type of savings. While these statements of savings give no indication of the amounts, the other evidence presented gives no reason to believe that they are large.

It was desired to find out whether these clients of baby health stations had ever made use of a private physician for health advice. Twenty-three per cent stated that they had at some time made use of a private physician for such service. Thirty-four per cent stated that they had not used a private physician because they had first been referred to the baby health station. Twenty-three per cent stated that they could not afford a private physician for a health service. About 18 per cent merely stated that they had never used a private physician for health advice, but failed to give the reason. Two per cent made no statement.

The present study has pointed to certain circumstances in the economic background of 501 clients of Bronx baby health stations. Most of these families are small, with three or four members each. Only about 13 per cent, however, report total annual incomes of more than \$50 a week, three-fourths reporting amounts less than \$50.

TABLE IV—ESTIMATED YEARLY INCOME REMAINING FOR EACH ADULT MEMBER OF 501 BRONX FAMILIES AFTER RENT AND HEAT BILLS ARE PAID

Number of Bronx Families	Yearly Income Per Adult Member Minus Rent and Heat	What These Incomes May Provide	Per Cent Total Families
36 (7)	\$200 and less	\$300 and less Dependence and Poverty	7.2
132 (56)	\$201-\$ 300	301-500 Bare Physical Maintenance	26.3
227 (82)	301- 400	501-800 Health and Decent Living Without Comfort	45.3
67 (37)	401- 500	801-1000 A Minimum of Comfort Without Luxuries	13.4
39 (39)	501- 600	Over 1000 Comfort	7.8
Total 501			100.0



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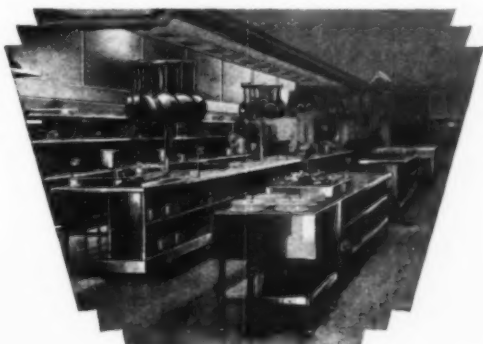
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More than 80 per cent of these families live in three or four-room flats, about one-fourth of them under congested and unhealthful conditions. Less than 15 per cent pay more than \$50 a month for rent and heat and about 70 per cent pay considerably less.

When the incomes of these families are compared with certain standard budgets indicating what the incomes might buy in the way of the ordinary necessities of life, only 21 per cent of the families are found to have incomes sufficient to provide for a minimum of comfortable living.

It was pointed out at the beginning that the data obtained in the interviews with these families were far from being considered adequate to the constructing of a complete and accurate picture of their economic situation. Accepting, however, the picture as presented, what conclusions may be drawn as to the ability of any or all of these 501 families to pay private fees for a health service for well babies?

Regarding the 79 per cent with incomes insufficient to provide for better than mere decent living under conditions of health, with little or no reserves for medical or other emergencies, it would seem unreasonable to conclude that these families could afford to pay private rates for a health service for well babies. Concerning the remaining 21 per cent with incomes sufficient to provide for minimum comfort, with some reserve for emergencies, the question might be raised as to their ability to pay private rates for a health service for well babies. The raising of this question with regard to 21 per cent of this particular group of families, however, does not mean to say that these families can pay private fees for this service. Still less does it mean to say that 21 per cent of all clinic clients or all baby health station clients can pay private fees for the service they receive at these clinics.

Before it can be definitely established that a given group of families can or cannot pay private rates not only for medical care in sickness but also for a medical and nursing service for well babies, such questions as these must first be answered: How much can they pay? For what specific service are they required to pay? How long can they continue to pay? What privations will they have to endure in order to pay? What have they already paid during the last twelve months for private medical care and nursing care? What do they still owe for such care? What is the likelihood of facing during the current year similar expenditures or exceptional expenditures such as a birth or an operation?

It will only be through a satisfactory answer to these questions that any valid judgment can be reached regarding the ability of families to pay for preventive or curative medical care.

Points to Consider in Organizing the Medical Staff

Serious thought and consideration must be given to the staff organization of the hospital, and the securing and retaining of a staff for both hospital and out-patient service must be conceded to be upon a basis of mutual interest and advantage, according to Dr. James B. Cutter, director, Children's Hospital, San Francisco. The following outline by an acknowledged authority on this point enumerates the policies involved as:

1. Staff organization inter-relating out-patient and in-patient service as closely as possible, interweaving policies of appointment and promotion.
2. Increasing the prestige of the hospital by enlarge-

ment, improvement in facilities, teaching connections and other means of bringing the hospital in a dignified manner to the favorable attention of the public.

3. Improvement of the out-patient facilities, increasing the professional advantages afforded the physician and the establishing of a strong esprit de corps, devotion to hospital tradition and the inculcating of the highest type of the spirit of service. When physicians do not forget the inculcating of their early ideals in the pressure of professional work and in the words of Carlyle, are ever mindful that "we touch Heaven when we lay our hand on a human body," the peculiarly sacred privilege of a staff appointment and the high point of moral obligation involved will each be kept in view as an inspiration and incentive to the highest type of service, beneath which nothing is acceptable.

Two essential principles must be considered in staff organization. One is that responsibility should be concentrated with one physician accountable for the service of which he or she is the head, both in the wards and in the out-patient department. The other principle is that individual service to the patient should be continuous, with the complete treatment of the patient under the direction of one physician. Application of this principle assures supervision by one physician from the time of the patient's admission to the out-patient department, through the hospital and his ultimate discharge to the follow-up clinic.

Staff conferences, as outlined by the American College of Surgeons, are of the greatest value and should not die out or become perfunctory. The educational importance of these conferences and their professional uplift cannot be over estimated.

The relations of the staff to outside physicians, the handling of complaints arising from the staff and the defining of lines between the medical and administrative features in various issues, bring many questions arising in the daily work of the hospital and clinic to medical and administrative consideration, and these questions must be frankly and fairly dealt with in open conference with a spirit of tolerance and good will. Smooth operation requires that in these and all matters affecting the care of patients, the medical and administrative authority must work together.

Use of Alcohol Is Decreasing in British Hospitals

The use of alcohol in British hospitals has decreased enormously since 1900, the *Journal of the American Medical Association* says. In 1900, in the four general hospitals of Liverpool, the patients were given six to seven ounces each; in 1906 the amount had dwindled to eight-tenths of an ounce a patient.

In 1915, at the Manchester Royal Infirmary, 123 gallons of wine and spirits were used; in 1925, with more patients, only twenty-six gallons were used. In the Western Infirmary, Glasgow, in 1888 every patient was given thirteen ounces of alcohol; in 1908, seven-eighths ounces; in 1925, three-eighths ounces. Following the disuse of alcohol in the Western Fever Hospital, London, diphtheria mortality fell from 8.54 per cent in 1925 to 3.01 per cent in 1927.

The medical research committee is asking nurses to discontinue using the word "stimulant" in connection with alcohol, saying that it is a narcotic drug and that it suspends or depresses the functions of the nervous system.

\$ 52,500,000 Raised for Hospitals

This is the record of Ward, Wells and Dreshman, the fund-raising firm which has secured more than a half billion dollars for philanthropic institutions during the past decade. It has directed campaigns for hospital funds in Paris, London, Dublin and Canada as well as throughout the United States.

A Partial List of Recent Campaigns

Jefferson Medical College and Hospital, Philadelphia (2 campaigns)	\$2,224,000
Fifth Avenue Hospital, New York City	1,850,000
Reading Hospital, Reading, Pa.	1,813,000
Post-Graduate Hospital, New York City	1,600,000
Doctors Hospital, New York City	1,600,000
United Hospitals, Rochester, N. Y.	1,395,000
American Hospital of Paris, France (4 campaigns)...	1,250,700
Children's Hospital, Buffalo, N. Y.	1,250,000
St. John's Hospital, Brooklyn, N. Y.	1,170,000
Osteopathic College and Hospital, Philadelphia.....	1,045,000
Arnot-Ogden Hospital, Elmira, N. Y.	901,024
Ohio Valley Hospital, Wheeling, W. Va.	876,000
Millard Fillmore Hospital, Buffalo, N. Y.	815,945
Union Protestant Infirmary, Baltimore, Md.	810,000
Flushing Hospital, Flushing, N. Y.	803,000
Washington Hospital, Washington, Pa. (2 campaigns)	775,227
St. John's Riverside Hospital, Yonkers, N. Y.	765,643
Allentown Hospital, Allentown, Pa.	645,000
North Wheeling Hospital, Wheeling, W. Va.	553,310
Miami Valley Hospital, Dayton, Ohio	515,000
Presbyterian Hospital, Denver, Colo.	500,000
Beck Memorial Endowment, London, Ontario.....	500,000
Maryland General Hospital, Baltimore (3 campaigns).	483,000
Paterson General Hospital, Paterson, N. J.	450,000
Provident Hospital, Baltimore, Md.	442,235
Women's Christian Assn. Hosp., Jamestown, N. Y....	438,700
Sparrow Hospital, Lansing, Mich.	435,009
Cape Cod Hospital, Hyannis, Mass. (3 campaigns)...	434,818
Memorial Hospital, Pawtucket, R. I.	422,190
Memorial Hospital, Buffalo, N. Y.	405,000
Sturdy Memorial Hospital, Attleboro, Mass.	390,500
St. Mary's Hospital, Grand Rapids, Mich.	384,316
Framingham Hospital, Framingham, Mass.	352,585
Eudowood Sanatorium, Towson, Md.	347,423
St. Mary's Hospital, Rochester, N. Y.	344,890
Children's Hospital, St. Louis, Mo.	330,000
Mercy Hospital, Pittsfield, Mass.	328,000
Mercy Hospital, Philadelphia, Pa.	319,568
White Cross Hospital, Columbus, Ohio	309,000
Norwood Hospital, Norwood, Mass.	260,000
Marietta General Hospital, Marietta, Ohio	253,000
Southside Hospital, Bayshore, Long Island, N. Y....	230,000
South Baltimore Hospital, Baltimore, Md.	224,200
St. Lawrence Hospital, Lansing, Mich.	206,000
White Plains Hospital, White Plains, N. Y.	200,000
Ohio Valley Hospital, Steubenville, Ohio	198,212
Redlands Community Hospital, Redlands, Cal.	190,000
St. Mary's Hospital, Amsterdam, N. Y.	177,342
Benedictine Hospital, Kingston, N. Y.	177,220
Maternity & Children's Hospital, Toledo, Ohio	168,500
Amsterdam City Hospital, Amsterdam, N. Y.	130,632
Ogdensburg City Hospital and Orphanage, N. Y.	123,369
Pottsville Hospital, Pottsville, Pa.	120,000
Dobbs Ferry Hospital, Dobbs Ferry, N. Y.	116,019
Saratoga Hospital, Saratoga Springs, N. Y.	116,000
United Helpers Home, Ogdensburg, N. Y.	116,000
Shenandoah Hospital, Shenandoah, Pa.	110,000

The Service of Ward, Wells and Dreshman

1. Campaigns are made intensively in ten day periods after from four to ten weeks of preparation.
2. A Director and his staff supervise the work of organizing the constituency, living with the problem from the first day of preparation to the hour of victory.
3. The Staff is comprised of highly trained men, selected for their leadership, personality and expert knowledge.
4. Publicity is prepared by experienced men with a view to creating permanent good will as well as the appeal.
5. A moderate fee based on the amount to be raised is charged. *No campaigns are undertaken on a commission basis.*
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7. Consultation is gladly given without cost or obligation.

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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

Sterilizers—How Many and What Kind Should the Hospital Have?

SINCE the sterilizer is so vital a part of hospital equipment it is well to understand the intricacies of the various types as well as their advantages and disadvantages. The subject of sterilizing equipment has been studied from all angles by engineers and the relative merits and demerits of each type discovered. Information used in this article is culled from a paper delivered by H. C. Russell at a recent meeting of the American Society of Heating and Ventilating Engineers.

Not only must the hospital sterilize all the instruments and utensils used in operations and treatments, but it must also sterilize all dressings before they are used, bedpans and babies' milk and bottles. Provisions must also be made for sterilizing dishes and mattresses. Instrument, dressing, utensil, dish and mattress sterilizers are usually rated by their internal dimensions in inches, water sterilizers by the gallon capacity of each of the two reservoirs, water stills by their capacity in gallons and Pasteurizers as well as bottle sterilizers by their capacity in eight-ounce bottles.

Steam Sterilizers Generally Used

Sterilizers and water stills may be heated by steam, electricity, gas, kerosene or gasoline. Steam, however, is the only method for which the entire line of sterilizers is ordinarily made. A steam heated sterilizer may operate indefinitely without any resulting injury. One heated by electricity should be equipped for protection against low water and overpressure. Gas, kerosene or gasoline heated sterilizers should have devices for protection against pressure but not against low water. Only in the case of the solution warmer is electricity superior to any other method. Its adaptability to automatic control makes it preferable.

The cost of operating steam sterilizer equipment is little more than the cost of keeping steam constantly available. In the open type of sterilizer the articles are immersed in a water bath heated by steam coils, the limited temperature being 212° F. In the closed type there is no water bath and the articles are brought into temperatures corresponding to steam at forty to sixty pounds pressure per square inch. The open type has the disadvantage of depositing lime or other impurities from the water on the instruments. In the closed type better sterilization is provided and the articles are dry when removed. This type of sterilizer must be used for dress-

ings and fabrics which must be thoroughly dried.

Built-in sterilizers are coming to be used more and more in operating suites and other places where they are installed at one point. However, only pressure type sterilizers that are loaded and unloaded from one end are adaptable to this arrangement. A thin partition is built flush with the sterilizer fronts. Only the doors, gauges and operating valves are visible in the rooms, the bodies projecting into an unfinished space behind the partition where they are accessible for repairs.

In the proportioning of equipment the following suggestions are made for what may be considered ordinary conditions.

One 16-inch by 24-inch dressing sterilizer will care for two major operating rooms, possibly three, but for more than two such rooms it is better to provide a 16-inch by 36-inch size or to install two 16-inch by 24-inch sterilizers. One 20-inch by 20-inch by 24-inch open type utensil sterilizer will care for two major operating rooms unless the work is very heavy. A 9-inch by 10-inch by 20-inch open type instrument sterilizer should be provided for each major operating room although one 10-inch by 12-inch by 22-inch may serve two such rooms. The 12-inch by 16-inch by 24-inch instrument sterilizer finds its use where it is convenient to sterilize from two or more major operating rooms at one place. A 14-inch by 22-inch pressure type will serve two major operating rooms easily.

Twin Reservoirs for Water

Water sterilizers consist of twin reservoirs of the same capacity mounted on one frame. One reservoir is for water kept hot by steam coil in the reservoir; the other is cooled by circulating cold water through a coil in the reservoir. Both sterilize their contents. Water stills are a part of the water sterilizing unit and consist of a still and reservoir mounted between the two water reservoirs.

Water sterilizers are available in sizes from 6 to 100-gallon capacity of each reservoir and stills in capacities of 1, 3 and 6-gallon reservoir capacity. The total capacity of the two reservoirs in the water sterilizer should range between 5 and 10 gallons per major operation per day. The 3-gallon still would suffice for hospitals up to 100 beds and the 6-gallon size should be used for larger ones in connection with the water sterilizers. Stills of the same capacity are obtainable which are separate from the

Hushed...

the wails of lusty young lungs



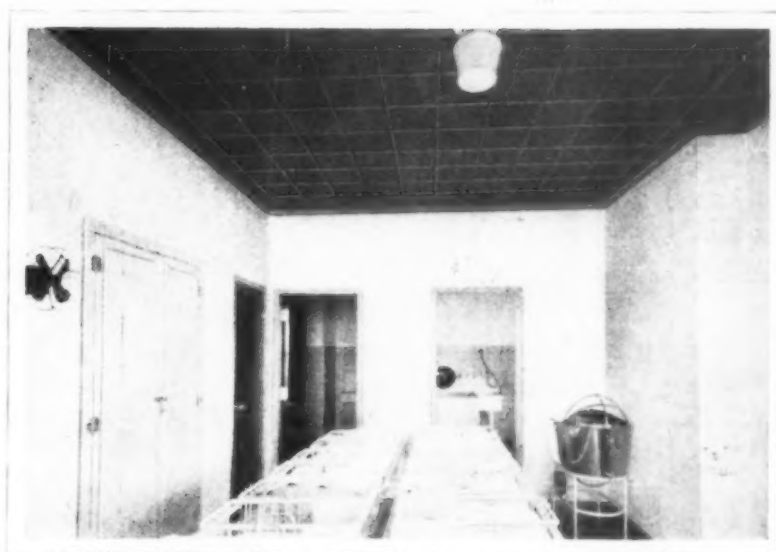
Calmed...

the nerves of mothers and nurses

IN the baby ward pictured here a great transformation has been wrought. The wails of new-born babies have been subdued by the application of Acousti-Celotex to the ceiling.

Comparative quiet reigns today. There is less chance of disturbing mothers in nearby rooms ... less cause for taut nerves among the attending nurses.

Here you have just one example of the use of a material that has already been applied in the country's leading hospitals. Not only in baby wards but wherever unusual and unavoidable noises arise to disturb and irritate patients and hospital staff. A few of these places are corridors, elevator lobbies in large city hospitals, serving rooms and utility rooms.



In the baby ward of St. John's Hospital, Tulsa, Oklahoma. The Acousti-Celotex ceiling works wonders in absorbing the noise from infant throats. Hospital architects—Wight & Wight, Kansas City, Missouri.

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Acousti-Celotex is sold and installed by approved Acousti-Celotex Contractors

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To tell you the interesting story of Acousti-Celotex in greater detail, we have prepared a

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Don't fail to see the Kent Exhibit while attending the Annual Convention of the American Hospital Association at Atlantic City, June 17 to 21. Among the machines displayed will be the new Model A, an exceptionally quiet machine designed especially for hospital use. Stop at Booth No. 8.

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Name and Address.....

water sterilizers. They are frequently needed in the maternity department.

The dressing, instrument and utensil sterilizers are primarily for the major operating rooms and should be in or adjacent to them. Where the operating rooms are scattered, all sterilizers with the exception of the one used for dressings should be duplicated for each location. Where built-in sterilizers are used, the fronts may open directly into the operating rooms, or when a single sterilizer installation is used for more than one operating room, it should be located in a separate room between them.

Controlled Heat Advised

Uncontrolled sources of heat, however small, should be avoided as much as possible in an operating room. In hot countries this is very important, for oscillating fans usually are not allowable in such rooms. In each minor operating room, such as for eye, ear, nose and throat, and in the dental clinic, a small electric sterilizer, usually about 5 inches by 6 inches by 16 inches, for instruments should be provided. These are made with brackets for wall mounting.

In the surgery and maternity departments and at convenient locations to rooms and wards, blanket and solution warmers should be placed. These are available in sizes of about 18 inches by 24 inches by 72 inches, and 18 inches by 30 inches by 72 inches, simply heated and divided into compartments. For wards and rooms they should be placed in or near the utility rooms.

A surgical dressing room may use the equipment of the main sterilizing room if adjacent to it, but if this is not possible, separate equipment should be provided. A 6-gallon water sterilizer, one 8-inch by 9-inch by 18-inch instrument sterilizer and a 16-inch by 15-inch by 20-inch utensil sterilizer will usually suffice for a small hospital.

In the laboratory there should be installed an autoclave, which is a dressing sterilizer without the jacket, for the wet sterilizing of material. A 16-inch by 24-inch size will be large enough for a 100-bed hospital, although two larger sizes, 18 inches by 26 inches and 22 inches by 30 inches, are available.

Equipment for Utility Rooms

Utility rooms should be provided on each floor and should contain, in addition to combination sink and tray, one 20-inch by 24-inch and one bedpan sterilizer. Utility rooms serving surgical and maternity patients also should contain an 8-inch by 9-inch by 18-inch instrument sterilizer and a 10 to 15-gallon water sterilizer.

Equipment for Pasteurizing milk and sterilizing bottles must be provided in the nursery. These may be combined in a small hospital, but in a large hospital this method is not satisfactory. Pasteurizers can be had in 54, 72, 144 and 288-bottle capacity, 8-ounce nursing bottles. About one hour is required for a cycle since laws frequently require that the Pasteurizing process consume 30 minutes. When bottle sterilizing is done separately, a pressure type sterilizer for nursing bottles is provided.

Where there are contagious diseases, dishes may be sterilized in special dishwashing machines or, on a small scale, in a 20-inch by 20-inch by 24-inch utensil sterilizer.

Every hospital should be provided with a mattress sterilizer. Although smaller sterilizers may be purchased that are arranged for gas or electric heating, mattress sterilizers are practicable only when heated with steam. The large size, 36-inch by 42-inch by 48-inch, is the most widely used, and may be charged at one end and discharged at the other. Because of this, it may be placed



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Manufacturers of the famous Trico Art Metal Radiator Cabinets. All steel furniture.



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Gentlemen—

"In keeping with our policy to adopt all modern equipment of proven value and utility in St. Luke's Hospital, we recently equipped all five of our Operating Rooms and several of our Wards with TRICO Art Metal Radiator Furniture with built-in humidifying water pans. A great improvement in the increased amount of humidity so vital in these Operating Rooms and Wards was instantly noticeable, and it is appreciated by our Medical Staff, Nurses and patients alike.

"We are entirely pleased with this Radiator Furniture and consider it one of the best and most needed installations ever made in our Hospital."

Very truly yours,
CHAS. A. WORDELL, Supt.
St. Luke's Hospital, Denver, Colo.

(Signed)

HOSPITAL UTILITY FURNITURE

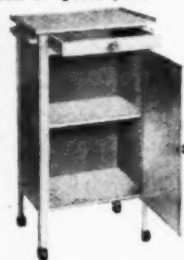
We are displaying our new and improved line of Hospital utility furniture. Our new Bedside Cabinet will bear your inspection. Hampers, Cabinets. All of steel. In many coats of enamel, beautifully finished. All shown for your inspection. For literature and details write us at address shown below. Write now for special hospital discount on our Radiator Covers—33½% our institutional discount. We shall be pleased to quote you.



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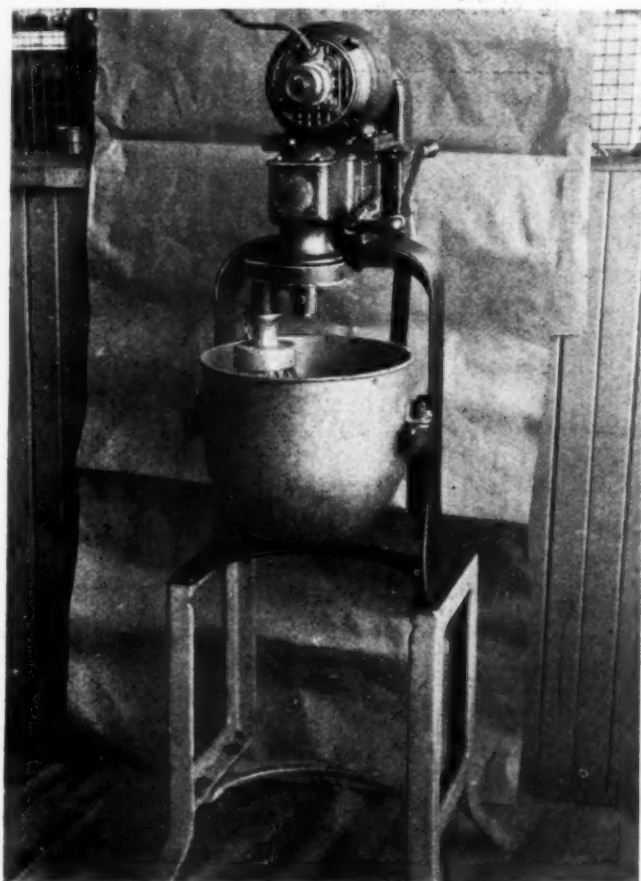
in a partition between two rooms and a complete separation of sterilized and unsterilized material effected.

Different manufacturers have sizes of sterilizers that are approximately the same but not absolutely standardized as to sizes. Hence, it is advisable to give inside dimensions and minimum capacity in cubic inches when specifying sizes.

Combination Mixing Machine Designed for Hospitals

A new mixing machine that has several advantages in design and principle over the old style machines was recently placed on the market. Its bowl, having a capacity of twenty-two quarts, was chosen as the most popular and satisfactory size for average hospital kitchens of to-day.

The mixer is unique in principle in that it employs the planetary motion of stirring, duplicating as nearly as



possible the motion of the human arm and wrist in folding the ingredients and then beating them by whips rotating in the same direction as the planetary motion. By use of this motion more air is folded into the mixture.

Attachments are provided whereby the machine can be used for grating, chopping, slicing, freezing, juice extracting and grinding. Special cans for regulating the flow of vinegar and oil, which are available at a slight additional cost, render the machine an ideal mayonnaise mixer. A special colander attachment transforms it into an efficient sieve.

The mixer is made to retail for \$140 without the special attachments.



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Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

THORNER BROTHERS

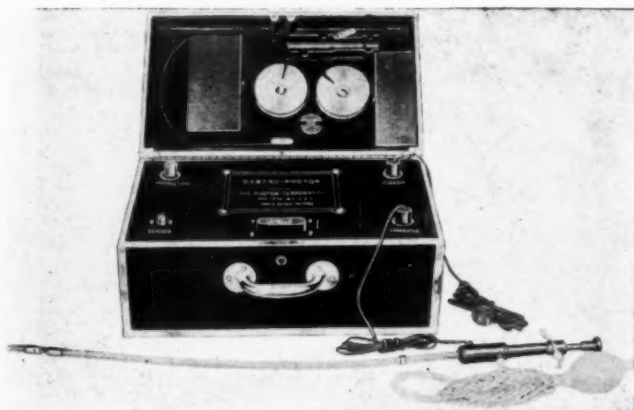
Importers and Manufacturers of Hospital and
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A New Invention for the Correct Diagnosis of Gastric Ills

Through the perfection of an apparatus invented by F. G. Back, D.I., and Dr. Joseph Heilpern for the First Vienna University Clinic, Vienna, Austria, the physician is enabled to photograph the interior of the stomach, the complete gastric mucosa, clearly and without danger or discomfort to the patient.

The instrument is similar to the normal rubber stomach tube but it has attached at the distal end a camera about two inches long and less than half an inch in diameter.



With this camera sixteen pictures are taken simultaneously and in less than a quarter of a second—four each anterior, posterior and bilateral on eight films. These are all clear stereoscopic views.

A tungsten filament lamp centrally located in the camera affords 12,000 candle power illumination, giving an intense blue light. The flash of the lamp destroys the filament in the lamp and also a similar filament in the transformer so that the electrical current is cut off instantly.

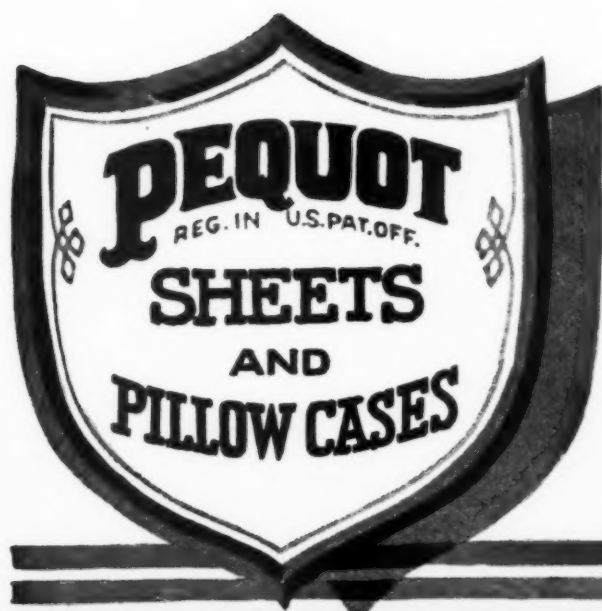
The transformer for energizing the lamp is mounted in a portable case of cast aluminum. It is designed so that it will take in only sufficient electrical current to operate the lamp, and it operates with either direct or alternating current, 110 or 220 volts.

Through the instrument more than 3,000 pictures of the interior of the stomach have already served the medical profession as an aid in diagnosis. The machine shows distinctly the difference between acute or chronic gastritis, gastric ulcers or cancer, and is a great help not only to the gastroenterologist but also to the surgeon, in diagnoses as well as in postoperative examinations.

Refrigerator Shows a 60 Below Zero Temperature

A refrigerator that is guaranteed to maintain a temperature of 40° F., below zero, and which in tests actually maintains a temperature of 60° F., below, has recently been manufactured. This machine, which was made especially for an industrial concern for the testing of rubber under antarctic conditions, contains the same refrigerating unit that is used in the household refrigerator produced by the same company.

The machine is operated on a new principle without the use either of gas or chemicals. The first machine was invented more than ten years ago to disprove the theory



are used more by
HOSPITALS
than any other brand
because of their

WHITENESS

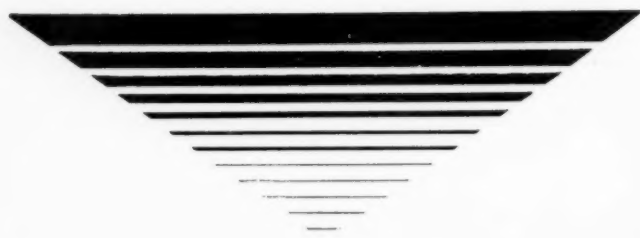


The glittering purity of fresh snow is gone tomorrow. But in a Pequot Sheet, whiteness endures—through years of wear and endless launderings. This permanent whiteness of Pequot is secured through slow, careful bleaching—in pure artesian well water—bleaching every thread white clear through—natural white, retaining all the natural strength of the fabric.

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JUNE 17-21

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CARBON ARC

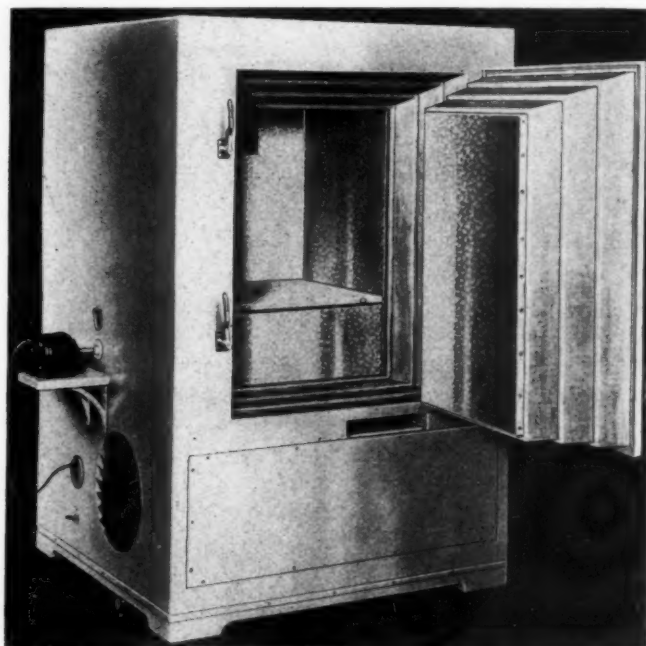
RADIANT LIGHT

INFRA RED

HEAT



that air could not be used as a refrigerant because of its unsuitable physical characteristics. To-day the manufacturers not only are producing refrigerators on the principle of using only air, but they are also making machines where temperatures as low as 100 degrees below zero are required. These machines have no valves, no piping, tubing or coils and no drains. They utilize only air.



In construction and operation the unit is comparatively simple. A single cylinder compressor is driven at slow speed and under low pressure by a quarter horse electric motor. All moving parts are housed inside the compressor body, where they are automatically lubricated, and are in turn surrounded by the air which does the refrigeration at less than 100 pounds pressure.

By a simple breathing action this air is guided inside the cylinder using the interchanger method. Heat is absorbed from the air until subzero temperatures are reached. The interchanger itself consists of a number of strips of brass, each 0.002 inches thick, wound on a special composition core. Surrounding this interchanger is a series of tinned copper fins which radiate the heat that is absorbed from the air inside the engine.

Simplicity of construction and design have solved service problems even when operating continuously at such low temperatures. The absence of frost removes the necessity of defrosting.

The Institutional Laundry—Its Value and Problems

That the laundry is not simply a mechanism for the performance of manual service alone, but a department equal to any other unit or division of the hospital, is the opinion of S. Frank Roach, superintendent of the laundry, Jersey City Hospital, Jersey City, N. J., who spoke on the institutional laundry, its value and problems at the annual meeting of the Pennsylvania Hospital Association.

The laundry is a requisite of the hospital, Mr. Roach declared. Size and capacity of the hospital will determine the amount of money to be spent for equipment. The pay roll must be considered since it starts with the in-

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DAY'S MODERN CUBICLE CURTAIN EQUIPMENT

an overhead system of suspension for cubicle curtains



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Columbia Presbyterian Medical Center	-	-	-	-	New York City
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Exclusive Features of Day's Cubicle Curtain Equipment

HOOKS—Roll past point of support.

SANITARY—Leaves floor absolutely unobstructed, no dust can collect.

SILENT—Hook glides noiselessly at slightest touch.

PRIVACY—Each bed instantly made a separate unit without effort.

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Prominent dietitians find this dish unusually tempting for ward service

Spanish Cream of Wheat

$\frac{1}{4}$ cup uncooked Cream of Wheat	
4 cups boiling water	1 green pepper, chopped
$\frac{1}{4}$ tsp. salt	1 stalk celery, chopped
1 small can tomatoes	1 sliced onion
3 tbsps. flour	4 tbsps. butter

Salt and pepper

Pour Cream of Wheat slowly into boiling salted water, stirring constantly. Put in double boiler and cook fifteen minutes. Cook onion, celery, pepper and tomatoes for ten minutes. Melt the butter, blend with flour and add. Cook until thickened. Season and serve with Cream of Wheat.

COLORFUL to the eye and tempting to the palate is this dish which dietitians in leading eastern hospitals make a practice of serving. It is particularly good as a stand-by for ward service, where appetites are hearty but expense is necessarily restricted.

A mound of fluffy, cooked cereal over which is poured a Spanish Sauce, rich with tomatoes, faintly suggestive of browned and simmered onion. The cereal is the one experience has shown is ideal for blending and combining in convalescent dishes—Cream of Wheat.

No undue strain upon weakened digestions results when Cream of Wheat is the basis of a dish—its simple, granular form is so easily handled. Recuperation is hastened by its abundant supply of carbohydrates, a concentrated way of supplying the nourishment doctors are constantly emphasizing.

Cream of Wheat is packaged in triple-wrapped and sealed cartons, free from all spoilage. And each package gives forty generous servings at less than 1¢ each. It is surprisingly economical to use, as dietitians clever in creating dishes have discovered.



FOR THIRTY-TWO YEARS A STANDARD FOOD
ON PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

stallation of the laundry. A considerable outlay of money is necessary, but in the end it will be found to be a sound investment provided the laundry has been efficiently supervised. In fitting up the hospital laundry, the best type and quality of equipment should be bought. It pays in the long run.

However, the machines alone cannot do the work. If the best equipment must be used, then it is an error to suppose that the operation of the laundry department demands a strong back and a weak mind instead of a well qualified supervisor. So often this is the cause of many hospital perplexities.

It is not necessary that a supervisor have an academic training in order to assume the responsibilities of the hospital laundry, but the position does demand a specially trained mechanic who is proficient in laundry procedure.

Laundry machines are not foolproof. They demand attention. Lack of attention means delays, always at the wrong time. In addition, it means repair bills—another name for wasted money.

Common complaints about the laundry largely concern delays, both in picking up the soiled linen and in delivering the laundered product, insufficient deliveries and poor quality of work. Delay is caused by a volume of soiled linen delivered to the laundry at a time when other work in process of reclamation has been placed in the machines. Other reasons for delay may be lack of help, which necessitates the use of inexperienced collectors who take more time than usual, increase of volume beyond the capacity of equipment and personnel and a general shortage of the total linen supply in use. The best suggestion that can be offered to meet this condition is that of making an inventory of what is in use. From this knowledge, many times the trouble can be ascertained.

There is only one satisfactory kind of soap to use in the hospital laundry, and that is the best obtainable. It cleans, leaves no trace of its use and adds life to the covering as well.

The most important feature of the laundry, however, is a supervisor who is sober, reliable, honest and industrious and who is thoroughly conversant with laundry management.

Card Offers Satisfactory Method of Locating Nurse

A satisfactory method of indicating the presence of a nurse in a room for those hospitals that cannot arrange a system of lighting is the use of a card carried in the pocket of the nurse and placed by her on a small rectangular brass hook on the door casing. These hooks are near the outer edge of the casing at a convenient height and on the side from which they may best be observed from either end of the corridor.

The cards are three and one-quarter inches by four and one-half inches and have a brass eyelet near the top. Students carry green cards and supervisors carry blue cards. Both groups have to be trained to put the card up when they enter the room and to replace it in the pocket when they leave the room. With the habit once established the system becomes very satisfactory. It relieves nervous wear and tear and is appreciated by doctors and others who have experienced the helplessness of looking at a row of closed doors in an empty corridor.

The idea may not be new but it has proved its value. Metal cards could be used for their wearing and washing qualities but the more fragile pasteboard is quiet, does

RESEARCH PROVES ANTI-RACHITIC PROPERTIES OF COCOMALT



Radiograph of the tibia of a rachitic albino rat showing the wide zone of decalcification, the so-called rachitic metaphysis. From this point on, a fraction of a gram of COCO-MALT was fed daily in addition to the basal rickets-producing diet (Ration 2965).



The same bone eight days later showing the beginning of the curative process. Note the deposition of calcium in the provisional zone of calcification.



This radiograph was taken at the termination of the experiment in the ninth week. Recalcification is complete and the animal is pronounced cured.

After many months of research by prominent authorities in the field of nutritional chemistry we are gratified to prove that Cocomalt, in addition to its many other attributes, contains vitamin D, the anti-rachitic vitamin which promotes normal ossification in bones and teeth. Without this vitamin or ultra-violet light, calcium and phosphorus deposition cannot occur, with the result that rickets develop. In addition, laboratory tests show that Cocomalt contains Vitamins A and B. Comparative tests also revealed the fact that Cocomalt contains, gram for gram, about the same amount of the vitamin B complex as raw whole wheat.

Cocomalt is not a medicine. It is a nourishing, easily digestible, natural food with a delicious chocolate flavor. Physicians who experience difficulty in persuading patients to drink milk will find Cocomalt palatable and invaluable.

Cocomalt increases the caloric value of milk 70%. For that reason alone it is useful in diets of convalescents when the physician wishes to build up body weight as rapidly as possible. Served with milk, Cocomalt makes an excellent supplement to the average dietary, adding proteins of the highest biological quality, mineral elements (especially calcium and phosphorus) in the proper proportions and vitamins A, B (complex) and D.

Cocomalt is recommended for convalescents, growing children and adults and can be fed to advantage wherever milk diets are indicated.

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not make holes in pockets and can be replaced when worn or dirty. The objection that might be raised to a soiled card in the pocket is almost negligible since the nurses all have a special pocket for the handkerchief.

The card system described is used by the Fabiola Hospital Association, Oakland, Calif., with entire satisfaction, according to Elizabeth M. Jamieson, director, school of nursing.

The Problem of Buying Supplies for the Small Hospital

An important problem that faces the superintendent of the small hospital is the buying of supplies, and looking after the business side of the hospital, according to Evelyn Buchan, superintendent, Weedn Hospital, Duncan, Okla., in a paper read at the annual meeting of the Oklahoma State Hospital Association. Miss Buchan says:

Supplies and equipment must be checked up and the depreciation noted. The laundry, kitchen, operating room, linen rooms, laboratory, x-ray, physiotherapy and general supply rooms must be carefully watched, all exhausted stock replenished and rigid economy and efficiency practiced throughout.

It is necessary to see that all supplies are bought in adequate quantities. Supplies are more often bought in too large quantities rather than too small—such things as rubber goods, tubing and other supplies that deteriorate with age. On the other hand, articles are often bought in small lots and broken cases that could better be bought in case lots at a saving.

The nurses' home is a constant source of extravagance if it is not watched. Lights, water and gas are invariably carelessly used. All these little wastes amount to a great deal in the small institution.

Doing Away With the Cold Food Bugbear

Getting hot food to the patient is a problem in almost all hospitals, and the method used at Pasadena Hospital, Pasadena, Calif., should be of interest to hospital administrators and dietitians. W. F. Vail, manager of the hospital, in the *Western Hospital and Nurses' Review*, tells how he manages to get piping hot food to the patients.

A small special diet kitchen was arranged on each floor. The theory of food service was based, not on the idea of getting carts that would keep the food hot for several hours, but on the theory of using food carts that would keep food hot for a reasonable length of time, and setting up the department in such a way that the trays could be served before they could possibly get cold.

The nursing unit is eliminated from the service of food, and the patients are served entirely by tray girls. The hot food is all prepared in the main kitchen, and is then sent to the sub-diet kitchens where it is immediately dished up, one tray at a time. This tray is immediately served. The trays are made ready by the tray girls in the hour preceding the serving of the food, and they also wash the dishes and take care of the diet kitchen afterwards.

From 175 to 180 trays are served in less than ten minutes, and under actual test 175 trays have been served in seven minutes flat.

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